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ABSTRACT

This manual is a guide for those who are planning preventive/restorative family service programs to provide alternatives to placing children in state foster care systems. Chapter I briefly discusses the rationale for family-centered social services. Objectives, characteristics, and advantages of these services are listed. Planning and implementation of family-centered services in the public sector are detailed in two major steps: identifying and involving key decision makers, and reviewing state funding policies and budgets. Chapter II describes family-based service delivery systems, highlighting three models: the Generalist-Specialist, the Intensive Family Services Unit, and the Purchase of Services; complete definitions and diagrams are included for each model. Chapter III outlines a system for classifying family needs, while Chapter IV provides an administrator's guide to client needs assessment. Chapter V deals with personnel concerns in family-centered services focusing on worker time allocation, job classification, and collective bargaining. Chapter VI is a comparative analysis of the costs of family-centered services and substitute care, and includes tables with supporting data. A glossary of terms and a bibliography are included, followed by an appendix outlining Oregon's family service contract requirements. (BH)

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FAMILY-CENTERED SOCIAL SERVICES:

A MODEL for

CHILD WELFARE AGENCIES

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FAMILY-CENTERED SOCIAL SERVICES:

A MODEL FOR CHILD WELFARE AGENCIES

DEVELOPED UNDER THE AUSPICES OF:
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TABLE OF CONTENTS

Chapter Page

I. Background of Family-Centered Social Services and Its Implementation 1
  - Introduction 1
  - Definition and Objectives 2
  - Characteristics of Family-Centered Services 3
  - Advantages of Family-Centered Services 4
  - Planning and Implementation 4

II. The Family-Based Service Delivery System 13
  - Introduction 13
  - Generalist-Specialist Model 15
    - A. Intake Service Component 18
    - B. Family Services Component 21
  - The Intensive Family Services Unit Model 27
  - The Purchase of Services Model 28

III. A System For Clarifying Family Needs 32
  - Introduction 32
  - Classification of Needs 34
  - Deployment of Staff Time 35
  - Criteria For Classification of Cases 36
  - Conclusion 37

IV. Administrator's Guide to Client Needs Assessment 42
  - Introduction 42
  - Definition 42
  - Assessment at Intake 43

On-Going Assessment 46

Assessment of Client Outcomes 48

V. Personnel Utilization For Family-Centered Services 54

Introduction 54

Worker Time Allocation 54

Job Classification and Collective Bargaining 56

VI. A Comparative Analysis Of The Costs of Substitute Care and Family-Centered Services 60

Introduction 60

Summary Cost Analysis 62

Glossary of Terms 69

Bibliography 74

Appendix A 88

LIST OF FIGURES

No	Title	Page
1	Client Pathway	16
2	Core Support Services	16
3	Service Pattern	17
4	Referral-Feedback Loop	20
5	Suggested Organizational Chart for the Generalist-Specialist Model	20
6	Service Functions	21
7	Service Planning	22
8	Referral in the Intensive Family Services Unit Model	27
9	Degree of Intensity in Terms of Service Hours Expended	36
10	Summary of Data Collection Instruments	52
11	Examples of Variable Tasks Associated With Family Typology Classifications	55
12	Extraordinary Work Week	57

LIST OF TABLES

No.	Title	Page
1	Service and Cost Results: Intensive Family-Based Programs	61
2	Computing Monthly Salaries	63
3	Computing Average Per Case Cost	64
4	Analysis of Foster Care and Institutional Care Cost for 1705 Children	65
5	Analysis of Family-Based Services Costs for 614 Families	66
6	Analysis of Foster Care Cost for 682 Children (40%) Discounted Over 3 Years	66
7	Maintenance Costs Saved By Not Placing 1023 Children in Foster Care	67
8	Net Benefits to Agency	67

Preface

The Children's Bureau's concern in recent years with the number of children entering state foster care systems has resulted in national efforts to promote family reunification and permanency planning. The Bureau is equally interested in the development of alternatives to out-of-home care with systematic approaches to the prevention of unnecessary and inappropriate placement.

Beginning in the mid 1950s, family-centered social services programs were developed in local communities under diverse auspices, often initiated as placement prevention demonstration programs in the private sector. The results reported by these programs created considerable interest among state children's service agencies and in the Children's Bureau. As a consequence of this interest and the prevention programming mandate in recent federal legislation, the National Resource Center on Family-Based Services was initiated at the School of Social Work, University of Iowa.

Since 1981, the Center has collaborated with a consortium of social service agencies, providing technical assistance and training in family-centered services as an alternative to placement. Planning preventive/restorative programs has included the review of state codes, agency policies and administrative structures. Technical assistance has focused on redeployment of resources, methods for financing family-centered services, and staff development needs, as well as developing a conceptual framework for family assessment and case assignment.

This manual is prepared as a guide for those who are planning preventive/restorative programs. The suggestions formulated by the authors and presented in this manual are based on direct practice experience and consultation with state and local administrators. The authors take sole responsibility for the contents.

Considerable work remains to be done in validating the concepts and hypotheses proposed in this document. It is hoped that they will provide the impetus to continue examining current child welfare services for better ways to provide cost effective services to families and to prevent unnecessary placements of children out-of-home. The comments and suggestions of readers are encouraged.

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CHAPTER I

BACKGROUND OF FAMILY-CENTERED SOCIAL SERVICES AND ITS IMPLEMENTATION

INTRODUCTION

Over the past several years, child welfare administrators, practitioners, and citizen advocates have participated in passing significant legislation that establishes reinforcing a child's family as an alternative to substitute care.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) prescribes that social services direct their family services: 1) to prevent unnecessary substitute placement; 2) to offer rehabilitation and reunification services to restore families whose children are in substitute care; 3) to assure permanent plans for children who cannot be reunited with their parents. The Act clearly mandates family-focused child welfare services and suggests a new system of social resources for families and communities.[1]

The National Resource Center on Family Based Services has been given a grant by the Children's Bureau to assist state and county social services agencies in implementing home-based family-centered services. Until recently, home-based family-centered services were provided almost exclusively by private voluntary agencies. Adaptation to the public agency posed significant difficulties for the following reasons:

1) Federal and state fiscal and program policies provided few incentives for developing preventive services.

2) The organization of the public agency into specialized units, which emphasized protective and substitute care services, creates structural barriers to implementing significant family-centered prevention services.

3) Client assessment is keyed to services available in the agency, rather than the needs of the family in its ecological context.

4) Caseloads are frequently too large to permit workers to work intensively with one family without seriously neglecting other families.

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5) Staff development programs focus primarily on training in agency procedures and offer little opportunity for workers to develop skills needed to work with seriously troubled families.

This manual addresses each of the above cited difficulties and offers guidance to public social service agency administrators in implementing home-based family-centered services. The underlying thesis is that public agencies are capable of providing quality home-based family-centered services with existing resources. Content draws on the work of family systems theorists and the experiences of the professional staff of the National Resource Center on Family Based Services, in consultation with state, county and voluntary agencies. The manual focuses primarily on policy and program development. Practice methods and techniques are reviewed in the companion volume, "Placement Prevention and Family Unification: A Practitioner's Handbook for the Home-Based Family Centered Program."[2]

I. DEFINITION AND OBJECTIVES

The framework of family-based, or family-centered, social work is derived from general systems and communication theories, drawing upon various approaches and ecological concepts.

"Family-centered services" is an approach to the delivery of social services that focuses on families rather than individuals. Services in the family-based context are intended to strengthen and maintain client families and to prevent family dissolution and out-of-home placement of children. The resources of the agency are focused on assisting client families in regaining or maintaining family autonomy.

The family-centered service concept is based on the following assumptions about children and families: 1) children need permanency in their family relationships for healthy development; 2) the family should be the primary caretaker of its children; 3) social service programs should make every effort to support families in this function.

The objectives of family-centered service are:

1) strengthening and maintaining client families;

2) preventing family dissolution;

3) preventing re-placement of children who have been reunified with their families;

4) reducing client dependency on social services by promoting family self-sufficiency; and

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5) promoting adoption of children for whom intense efforts at reunification have failed.

II. CHARACTERISTICS OF FAMILY-CENTERED SERVICES

An examination of exemplary family-centered programs throughout the country reveals the following key elements:

1) Accurate Assessment

Family-focused assessment includes the family's entire ecological context, essential for strengthening and maintaining a given family.

2) Optimum Timing

The flexibility to be available at critical times creates effective crisis intervention and is a crucial element in the prevention of regression and family dissolution.

3) Ecological Systems Approach

Involving the entire family and community affecting the family provides sustained support, a crucial element in preventing re-placement of children who have been reunified with their families.

4) Real Coordination

Family-centered coordination differs from case management in that it occurs from the locus of the family home, giving the primary worker more flexibility to communicate quality information when it is most advantageous to various helpers.

5) Techniques Appropriate to Need

Family-centered workers are trained to utilize the immense strength of variables such as culture, values, cognitive styles and pace in order to creatively tailor interventions which facilitate real growth.

6) Improved Motivation

Strong worker-family relationships and the development of the familys' own resources encourage families to take risks. These are key elements in promoting independence and family self-sufficiency.

III. ADVANTAGES OF FAMILY-CENTERED SERVICE

A. Reduces Out-of-Home Placements

Programs which focus on preventive in-home services consistently demonstrate their ability to maintain and strengthen families that would otherwise have been separated.[3] Results indicate that there is a growing body of knowledge and practice which can prevent unnecessary placements.[4]

An analysis of exemplary family-centered placement prevention programs reveals that they share two underlying principles:

1) An ecological orientation to child welfare practice, which considers the child in his/her family context. Ecologically-oriented child welfare practice supports the biological family and refers to family systems theorists for frameworks to understand the internal dynamics of families.[5] The systems orientation prompts practitioners to extend the ecological concept and to examine the interactions between family and important community systems.

2) Sufficient flexibility so that programs and interventions are responsive to the families' real needs. Much existing expertise has not been practiced because service designs do not permit the requisite flexibility which family-centered services encourage.

B. Is Cost Effective

Family-based services consistently demonstrate significant cost savings when program expenses are compared with foster, group and institutional care costs. Even when cost estimates for successful prevention of child placement are conservative, significant savings in maintenance costs over the average length of time a child remains in care can be expected.[6] See Chapter VI for an analysis of cost/benefits.

IV. PLANNING AND IMPLEMENTATION

Planning and implementation of family-centered services in the public sector require the involvement of all agencies and individuals providing services to client families. The groundwork must be carefully laid before workers can employ family-centered service techniques successfully. The following discussion centers on three steps an administrator might take in developing family-centered social services policies: 1) identifying and involving key decision makers; 2) reviewing state funding policies and budgets; and 3) clarifying the agency's policies to the service community and the public. The first step includes a listing of various target groups and organizations which affect the success of family-centered services.

Step 1. Identifying And Involving Key Decision Makers

The success of family-centered services depends, in great part, on the commitment made by public policy makers and community leaders. Family-centered goals should be discussed with key individuals and organizations to gain their support and involvement. Key target groups include: state legislators, juvenile and family court judges, attorneys and guardians *ad litem*, child advocacy organizations, medical associations, hospital and specialty teams, minority group representatives, and other community leaders and organizations. These are each separately discussed below.

A. State Legislators

State legislators may be enlisted to gather support for planning and implementing family-based services. Several state legislatures have passed legislation specifically mandating such services[7] or have authorized to family-centered services an allocated percentage of funds earmarked for foster care maintenance payments.[8]

Legislators should also be apprised of the pre-placement prevention requirements in P.L. 96-272, especially those pertaining to the judicial determination that reasonable prevention efforts be made prior to placement; to fair hearings for those denied benefits under the federal law; and to procedural safeguards when a child is removed from home.

P.L. 96-272 is a clear mandate to states to develop services for the prevention of unnecessary removal of children from their families. States are required to make reasonable efforts, as determined by the court, to prevent or eliminate the need for removal of a child from his/her home, in order to be eligible for federal matching funds for the child's foster care expense. Although "reasonable efforts" are not clearly defined, states are directed to specify in their Title IV-B state plans "which preplacement preventive and reunification services are available to children and families in need."[9] (Home-based family services is specified as a service that may be included in the plan.) There are strong fiscal incentives through the federal matching funds mechanisms, affecting both Titles IV-E and IV-B, to provide pre-placement prevention services uniformly across a state.

B) Juvenile and Family Court Judges

Juvenile and family court judges directly influence whether a child should be placed out of the home. Legislation supporting prevention of placement is meaningless unless those who make this decision are convinced of the value of family-centered services. Therefore, the support of judges should be actively solicited in formulating policy.

P.L. 96-272 does not specify at what stage in the juvenile court proceeding judicial determination must be made concerning reasonable efforts to prevent unnecessary placement. However, it is clear that judicial determination must occur prior to placement.

It was noted by an attorney, who reviewed the implementaion of P.L. 96-272 in several states, that many juvenile and family court judges interviewed were not aware of the 1980 federal law. Since local judges work with state law, this may not be surprising. However, the law and analyses of its provisions may be made available to local judges to help them understand their role, as well as the agency's, in preventing placements.[10]

C. Attorneys and Guardians Ad Litem

As legal representatives, these individuals will be advocating for or against placement of their clients and making recommendations in behalf of families. Legal personnel need to be aware that family-centered services is a method for ensuring their clients' rights to treatment. For this reason, their active support in policy-making should be sought.

D. Child Advocacy Organizations

Child advocacy organizations can be effective allies in promoting the family-centered approach because of their linkages to other community organizations and the public. They may be willing to publicize and support family-centered programs in their communities and may be included in the early stages of program development.

E. Medical Associations, Hospital and Specialty Teams

Members of the medical profession frequently demand immediate out-of-home placement of children who come to their attention as victims of child abuse and neglect. These professionals should be informed of the effectiveness of intensive family-centered services in diffusing potentially dangerous family situations. Their cooperation with the social service agency and the court should be sought in developing appropriate in-home treatment plans for selected patients.

F. Minority Group Representatives

Representatives of minority groups should be sought for their help in developing family-centered policies. Minority children are consistently over-represented in substitute care.[11] However, minority groups historically have been excluded from formulating policy that affects minority children.[12] This results in a self-perpetuating, discriminatory social service system in which minority group children are placed in substitute care in disproportionate numbers to non-minority children. Agencies interested in implementing the family-centered approach must significantly involve minority persons who represent the agency's client population in every aspect of preventive services planning.

G. Other Community Leaders and Organizations

Influential individuals and groups in the community need to be identified and their support solicited. These may include school board personnel, local officials, Parent Teacher Associations, etc. Such individuals and groups will be helpful in bringing the concept of family-centered service to community organizations which presently may have limited communication with the social service system.

H. All the Above

As stated in a paper introducing the federal Child Welfare Act to juvenile court judges, "P.L. 96-272 requires profound changes in many state child welfare systems but also allows for considerable local variations in how it may be implemented." [13] The Federal Act was the product of individuals and organizations representing the entire child welfare community: legal, social work and mental health professions, child welfare advocacy organizations and individual citizens. The National Resource Center on Family Based Services has proposed that its project states develop task forces, which are similarly representative of the state's child welfare community, to develop policies for the protection of families. The agenda is clearly the development of "reasonable alternatives" to the unnecessary removal of children from their families, but may begin with the development of a mission statement that clarifies the role of the social services agency in supporting and supplementing families in need.

Task force members may assist in reviewing the administrative policies and procedures currently in effect to determine which need strengthening and which may actually impede pre-placement prevention and reunification programming. A task force of service personnel in the Division of Social Services for the Commonwealth of Virginia undertook a similar mission in 1981. The results of their policy analyses and needs assessment were published by the Division, providing the impetus for a re-direction in service focus in that state.[14]

An intergovernmental body of administrators of all state and/or county human service providers, including the judicial branch, mental health and youth services, may also be useful in clarifying the interrelationships of the above entities in family-centered service delivery. Although, joint problem-solving is often difficult, time-consuming and tedious, a successful partnership increases efficiency in the use of resources and increases the involvement of participants in the recommended changes. [15]

Step 2. Reviewing State Funding Policies and Budgets

Perhaps the first task in developing family-based programming in the public agency is to conduct a critical analysis of the state's current funding policies across program lines in the human services. The Federal Block Grant initiatives have redrawn some of these lines, while giving state legislators greater authority in the allocation of funds. State social service agency administrators have an opportunity to influence the direction of the legislature. Programs that have little political salience may offer new funding opportunities for administrators who propose a convincing argument for change. Administrators should find a willing audience among legislators when they have a proposal that projects cost benefits from the reduction of foster, group, and institutional placements that may affect not only the social services budget, but also the corrections budget.

Social service agencies are currently funding services which have the potential to be family-based. Child abuse and neglect services are a prime example. The workers' caseloads may currently exceed the desirable level for intensive services with families. However, child abuse state grant (93-247) money might be used to launch a pilot project that with additional workers would demonstrate the eventual cost-effectiveness of the family-centered approach. [16]

Several states have encouraged county agencies to initiate their own pre-placement prevention programs by offering seed grants and by capping foster care maintenance funds with the option of using maintenance cost savings for prevention work. [17]

Because of reductions in both state and federal funds for social services, and the necessary compliance with the prevention provisions in the Federal Child Welfare Act, the impetus for reform is present. If the reform suggested offers measurable indicators of cost-efficiency and effectiveness, it is likely to win the necessary converts.

Although implementation may require an initial commitment of agency financial and staff resources, the savings in maintenance costs for foster and institutional care during the first twelve months of service should offset this initial investment. (See Cost Analysis, Chapter VI.)

Step 3. Clarifying The Agency's Policies To The Service Community And Public

The agency's policies to support and strengthen families in crisis, as an alternative to child placement, will enhance the agency's positive image with the service community and public.

That families be given the help they need to maintain their integrity and to succeed in raising their children is a compelling idea. Yet, it is also important to assure everyone that children will not be left unattended in dangerous circumstances and, when necessary, will be removed.

CONCLUSION

There is a strong desire on the part of most social service administrators, with whom the National Resource Center on Family Based Services has worked, to de-emphasize the use of substitute care. However, firmly entrenched policies and practices make change difficult. The political advantages of unpopular and generally untried changes are few. However, the mandate for pre-placement prevention and reunification programs in the Child Welfare Act is clear and the time for implementation is now. It is hoped that the new law will be sufficient basis for overcoming resistance to change.

The following chapters deal, in the main, with home-based family-centered program development and provide approaches helpful in designing a family-centered service delivery system.

FOOTNOTES

1. June H. Brown, et al., Child Family Neighborhood (New York: Child Welfare League of America, 1982), p. 6.

2. June Lloyd and Marvin E. Bryce, *Placement Prevention and Family Unification: A Practitioner's Handbook for the Home Based Family Centered Program* (Iowa City, Iowa: National Resource Center on Family Based Services, 1980).

3. For example, Mary Ann Jones, *A Second Chance for Families* (New York: Child Welfare League of America, 1976).

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4. For example, J. Torczyner and Arleen Pare, "The Influence of Environmental Factors on Foster Care," *Social Service* Review 53:3 (September 1979):358-77.

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5. Joan Laird, "An Ecological Approach to Child Welfare: Issues of Family Identity and Continuity," in *Social Work Practice: People and Environments*, ed. Carel B. Germain (New York: Columbia University Press, 1979) p.177.

6. For example, Marvin Burt, "Final Results of Nashville CES," *Child Welfare* LV:9 (November 1976):61-4.

Jill Kinney, Barbara Madres, Thomas Fleming, David Haapala, "Homebuilders: Keeping Families Together," Journal of Consulting Clinical Psychology 45:4 (1977):667-73.

Beatrice Ferleger and Mary Colter, eds., Children, Families and Foster Care: New Insights from Research in New York City Community Council of Greater New York, (New York: 1976).

Alfred Kahn and Sheila Kammerman, Not for the Poor Alone, (Philadelphia, PA: Temple University Press, 1975).

7. States which have passed legislation mandating preventive services include, for example, Colorado (Senate Bill 26 (1979); Maryland (Senate Bill 143, Chapter 432); New York (Child Welfare Reform Act of 1979, Amended 1980); and Washington (Title 13, Chapter 1332A Juvenile Code).

8. States which have authorized allocations to family-centered services of a percentage of funds earmarked for foster care maintenance payments include, for example, Colorado, Iowa and Minnesota.

9. "Foster Care Maintenance Payments, Adoption Assistance, and Child Welfare Services; Final Rule," Federal Register 48(100), May 23, 1983, pp. 23104-23119.

10. Diane Dodson, Assistant Staff Director of the National Legal Resource Center for Child Advocacy and Protection, speaking at the National Dissemination Conference on Family-Centered Alternatives to Foster Care, May 25-26, 1983, Sheraton National Hotel, Arlington, VA.

11. For example, Sheila Kammerman and Alfred Kahn, Social Services in the United States, (Philadelphia, PA: Temple University Press, 1976), pp. 217-220.

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12. Andrew Billingsley and Jeanne M. Giovannoni, *Children of the Storm: Black Children and American Child Welfare* (New York: Harcourt, Brace, Jovanovich, 1972).

13. Hardin, p. 3.

14. Virginia Department of Welfare, Division of Social Services, *Reprogramming Social Services for the Eighties: A Family-Focused Approach*, (June 1981).

15. Robert Agranoff and Valerie A. Lindsay, "Intergovernmental Management: Perspectives from Human Services Problem Solving at the Local Level," *Public Administration Review* 3 (May/June 1983):227-237.

16. Ira Barbell, Director of the Division of Children and Family Services, South Carolina Department of Social Services, speaking at the National Dissemination Conference on Family-Centered Alternatives to Foster Care, May 25-26, 1983, Sheraton National Hotel, Arlington, VA.

17. States which have offered seed grants or capped foster care maintenance funds with the option of using maintenance cost savings for prevention work include Colorado, Virginia, Oregon and New York.

CHAPTER II

THE FAMILY-BASED SERVICE DELIVERY SYSTEM

INTRODUCTION

The last two decades have seen the proliferation of services intended to support, supplement or substitute for the care of children by their parents. Response to service needs, recognized at different times and sanctioned by specific legislation and appropriations, has produced separate, sometimes competing policies, priorities and staffs for each categorical service. "As a result, uncoordinated, fragmented approaches are dictated by the nature of the system and cannot relate coherently to the entire life needs of an individual child." [1] Or, we would add, the family.

There are three principal problems with categorized services:

1) Clients must meet the agency's definition and category of service for services to be responsive.

2) The significance of a specific service category is directly proportional to the size of its fiscal appropriation and the political salience of its constituent or advocacy group.

3) Service units tend toward isolation and workers tend toward "specialization". The result is overlapping case assignments or gaps in service.

The current system of categorical services disperses clients in a relatively systematic fashion. For example, if a protective services worker is overburdened with cases, it is possible to place the children of particularly problematic cases in foster care, transfer the entire case or the child's case alone to the foster care worker, thereby relieving the protective services workers of responsibility. Although another case is likely to be assigned to the worker immediately, the movement of cases has a palliative psychological effect for both the worker and agency.

The movement of cases from unit to unit within the agency also gives the appearance that client problems are being resolved. Although this is an unflattering portrayal of a child welfare system, it is not uncommon.

In recent years, client advocacy models and case management and coordination models have been developed to reduce barriers to service inherent in categorical systems. These efforts do not seem to have solved fragmented service delivery, nor those problems related to categorical services.

Kadushin notes the criticisms aimed at the methods and procedures of service delivery in the child welfare system. One criticism cited is "...that service is fragmented, poorly coordinated vertically and horizontally, and discontinuous."[2]

In the same article, Kadushin states that future efforts in child welfare should focus on "...increasing interorganizational integration of the system and intraorganizational administrative efficiency, increasing technical competence to do the jobs society has assigned the system and assimilating the disconcerting changes of the immediate past."[3]

Interorganizational integration begins with the recognition that the service delivery system includes all of the resources both within and outside the public social service agency. The local public agency is the nucleus of the community's social service system and, as such, has a central role in ensuring that the optimal mix of resources is available and accessible to at least meet the minimum needs of families.

Matching resources to needs can be accomplished through direct service provision, purchase of services, and through the leadership of agency administrators who can alert the community to deficiencies such as housing, recreation, and medical services. Although the agency is not responsible for providing these services, deficiencies in these areas may cause or exacerbate the clients' problems. Interorganizational problem-solving may be achieved informally in small communities or by formalized partnerships of intergovernmental bodies or mechanisms.[4]

It may also be possible to achieve both interorganizational and intraorganizational integration and efficiency if agencies responsible for child welfare emphasize supportive and supplemental services (i.e., family-centered services), rather than substitute care services. Integration and efficiency may be achieved by adopting an holistic service philosophy and re-designing the service delivery system accordingly. Family-centered services provide such an approach and should be considered an alternative to the current system -- not an addition to it.

A review of the service delivery systems in state and county agencies reveals that attempts to include family-centered services have been approached in much the same manner as protective services, adoption, and other services for "special" client groups. Family-based services are added onto an already complex organizational structure and given status equal to the perceived importance of their particular constituent population.

Thus, family-based services programs have not yet achieved the recognition accorded child abuse and foster care programs in the service delivery system. The failure of the social services administration to view all of these constituent groups as part of the same fabric reflects an historical preference for serving the individual alone rather than as part of his/her family.[5] The redesign of compartmentalized systems may be necessary in order to recognize the family as the principal client.

This chapter presents service delivery models that emphasize family-centeredness and worker flexibility necessary for meeting the needs of families in their ecological context.

The three models discussed are:

1) the Generalist-Specialist Family Service Division, which is an alternative to categorical services for children, adolescent status offenders and adolescent parents. This model's description is more detailed and delineated not only because it proposes overall organizational and structual changes, but also because it is likely to be most effective in providing family-centered services.

2) the Intensive Family Services Unit, designed to serve those families at greatest risk of imminent dissolution; and

3) the Purchase of Services Model which, like the Intensive Family Services Unit, is designed to serve high-risk families, but is purchased from private, voluntary agencies.

These models have three similarities:

- the focus of service delivery is on the family as a whole rather than an individual family member;
- service is generally provided in the family's home; and
- the degree of intensity of service provided, in terms of hours expended per client family, is dictated by the family's particular needs.

I. GENERALIST-SPECIALIST MODEL

The Generalist-Specialist Family Service Division model proposed by the National Resource Center has at its core a strong, influential central intake component and a family services component as depicted [illegible] the client path diagram in Figure 1.

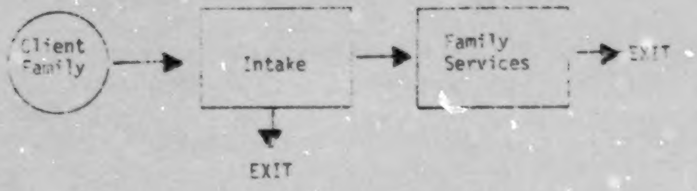
Client Family
Intake
Family Services
EXIT
EXIT

Figure 1. Client Pathway

The design depicted in Figure 2 includes core support services such as parent aides (PA), day care (DC), recruitment and licensure of foster and adoptive families (R&L), respite care (RC). The resources of these support services are used by the family's worker as needed, with the exception that out-of-home care and treatment are used only when all other alternatives have been exhausted.

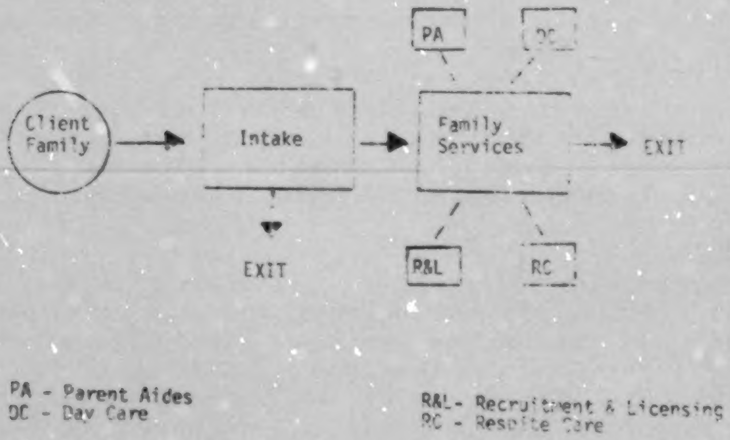
PA
DC
Client Family
Intake
Family Services
EXIT
EXIT
R&L
RC
PA - Parent Aides
DC - Day Care
R&L - Recruitment & Licensing
RC - Respite Care

Figure 2. Core Support Services

Service units within the Family Service Division may be composed of 5-8 generalist workers with a supervisor. Home-based family-centered services specialists suggest that units not exceed five workers since the supervisor may find it advisable to actively assist workers with more problematic families.

In this prototype, protective services, reunification and adoptions are functions carried out within the family services component by the primary worker. Specialists in child abuse, sexual abuse, family therapy and special needs adoption may also be located within the family services component as depicted in Figure 3. However, they should not carry caseloads. Trained in their specialties, these specialists are called upon by the family's worker and become a part of the family's service team when their expertise is needed.

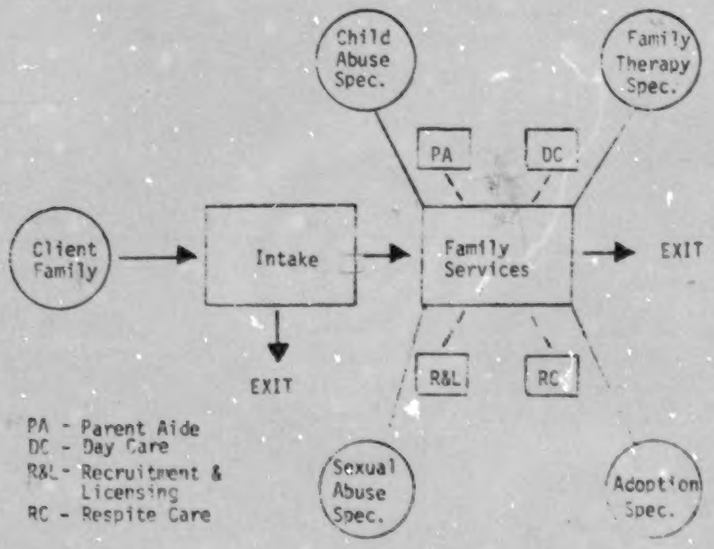
Child Abuse Spec.
Family Therapy Spec.
PA
DC
Client Family
Intake
Family Services
EXIT
EXIT
R&L
RC
PA - Parent Aide
DC - Day Care
R&L - Recruitment & Licensing
RC - Respite Care
Sexual Abuse Spec.
Adoption Spec.

Figure 3. Service Pattern

The specialists-consultants strategy is suggested for three reasons:

1) The agency can take advantage of its most skilled workers in a particular treatment or service speciality. Not only are specialists provided with opportunities for training in their area, but families will benefit from these individual skills.

2) The direct involvement of specialists gives the generalist worker an opportunity to observe, participate in, and learn treatment interventions specific to the specialty area.

3) The desired two workers per family suggested by in-home family-based practitioners can be accomplished, at least during the period of service delivery, when intensive intervention is needed.

The client pathway from entry into the system to exit in the generalist/specialist model has few, if any, diversions. One worker is assigned to and works with the family throughout, coordinating the use of resources within the agency and community. The worker and the family collaborate on problem-solving with the consultation of specialists and supervisory personnel, parent-aides, and possibly foster parents.

The following description of the system design includes the definition of the two service components (intake and family services), an introductory discussion of these components' functioning, and the sequencing of interactions among agency personnel and clients.

A. INTAKE SERVICE COMPONENT

Definition

Intake is the point at which the individual or family comes into contact with the system and during which the problem that prompted contact is preliminarily assessed to determine the type and scope of resources needed. It is also the point at which the services available through the agency and the larger community are explained to and explored with the family.

Intake is a critical function. The work done in the intake component lays the foundation for continued interactions with a family, both in serving its particular needs in a timely, sensitive manner and in determining the type and extent of resources required to address the family's problems.

The quality of work done at intake will have a direct bearing on the effectiveness and efficiency of interactions between workers and clients in the subsequent processes. It also follows that workers assigned to the intake unit must be motivated and professionally qualified to carry out this function.

The sequence of interactions and decisions that takes place during intake depends on two factors: 1) the time-critical nature of the problem(s); and 2) the suitablity of the system's resources to respond to the problems.

There are potentially four intake functions: 1) assessment; 2) protective services investigation; 3) crisis intervention; and 4) information and referral. Each will be discussed below.

1. Assessment Function

Home-based family-centered service providers strongly recommend that assessment occur in the family's home. Where information about the family and community systems is likely to be more accurate and readily obtained through direct observation.

With the client family, the worker: 1) identifies the client's immediate problem(s); 2) develops a profile of preliminary assessment information; 3) determines whether the family's needs can best be addressed by the system or other community resources; and 4) provides immediate help to the family when appropriate. The first interview should be accomplished within twenty-four hours of the family's initial contact with the system, unless the time-critical nature of the problem indicates a need for immediate response.

Following preliminary assessment of the service needs, the intake worker refers the family to the family services component or, when appropriate, another agency in the community.

2. Protective Services Investigation Function

This function is an investigative response to reports of child abuse and potentially serious neglect. Abuse or neglect (generally reported by a third party) is not substantiated until confirmed by an investigation of the child's condition and the family's circumstances. Protective services investigations may be conducted by intake personnel trained in protective services, or by a unit of specialists located in the intake component. The placement of this function within the system depends on the size of the agency and on requirements of the state's child abuse statutes.

3. Crisis Intervention Function

Crisis is defined as an unanticipated, unusual event that requires immediate response and solution. The agency may choose to designate crisis functions to intake or to a cadre of crisis workers who are on twenty-four hour call and are located in the intake unit. The size of the agency and number of emergency calls handled will determine the selection of the crisis intervention mode. Families in crisis, for whom the agency is actively providing services, should be referred to the family's worker whenever possible. All other crisis reports may be addressed by the intake or crisis worker.

4. Information and Referral

This function is the recommendation that the family seek assistance from another agency after preliminary assessment of the family's circumstances indicates that they are not within the agency's authority to address, or that they can be more appropriately addressed by another agency or organization in the community. Referral should be accompanied by follow-through and follow-up functions, as shown in Figure 4. Follow-through is identifying the appropriate referral resource and assisting the family in making the contact. Follow-up is determining whether the family has been able to obtain services from the agency to which they were referred.

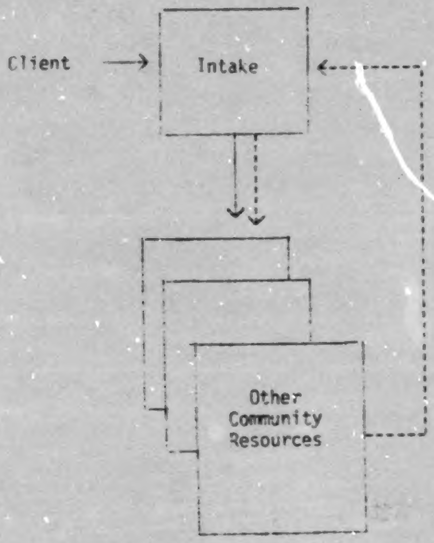
Client
Intake
Other Community Resources

Figure 4. Referral-Feedback Loop

Whether one worker performs all four of these functions, as is often the case in small agencies with a low volume of referrals, or whether certain functions such as protective services investigations and crisis intervention, are performed by designated workers, they are appropriately intake functions and should be located in the intake unit.

A suggested organization chart depicting the structural location of the function described above is shown in Figure 5.

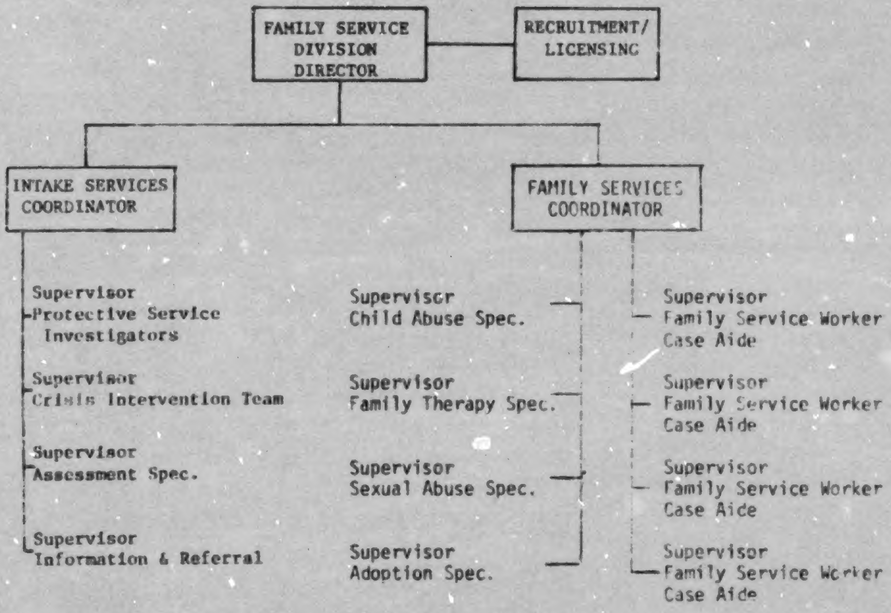
FAMILY SERVICE DIVISION DIRECTOR
RECRUITMENT/ LICENSING
INTAKE SERVICES COORDINATOR
FAMILY SERVICES COORDINATOR
Supervisor
Protective Service Investigators
Supervisor
Crisis Intervention Team
Supervisor
Assessment Spec.
Supervisor
Information & Referral
Supervisor
Child Abuse Spec.
Supervisor
Family Therapy Spec.
Supervisor
Sexual Abuse Spec.
Supervisor
Adoption Spec.
Supervisor
Family Service Worker
Case Aide
Supervisor
Family Service Worker
Case Aide
Supervisor
Family Service Worker
Case Aide
Supervisor
Family Service Worker
Case Aide

Figure 5. Suggested Organizational Chart for the Generalist-Specialist Model.

After determining that the family's problems are within the agency's capacity, referrals are then reviewed by the intake supervisor and the family services supervisor for appropriate worker assignment within the family services component.

B. FAMILY SERVICES COMPONENT

Definition

The family services component provides a full range of social services to individuals within a family context, recognizing that one person's behavior influences the behaviors of others.

The functions performed by the family service component include on-going assessment and service planning, service provision and case review, as depicted in Figure 6. These functions are defined and described in the following paragraphs.

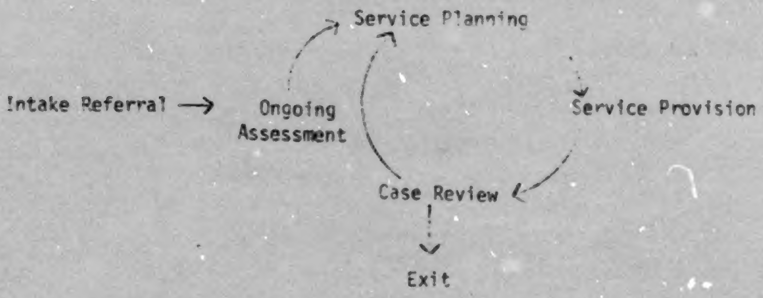

Figure 6. Service Functions

1. Family Service Component: On-Going Assessment

Assessment involves identifying a family's strengths and needs and making an in-depth analysis of the family's current level of functioning and its potential for regaining or achieving an acceptable degree of stability. Although on-going assessment occurs within the same time-frame as service planning and both influence one another, each component will be separately discussed. On-going assessment, as well as service planning, is a dynamic process involving interactions between family members, workers, supervisory personnel, and resource persons in the community. The sequence of the on-going assessments interactions and activities and their decision points will vary according to the client family's needs and, it should be stressed, will continue throughout the family's involvement with the agency. These interactions and decision points, as depicted in Figure 7, are discussed below.

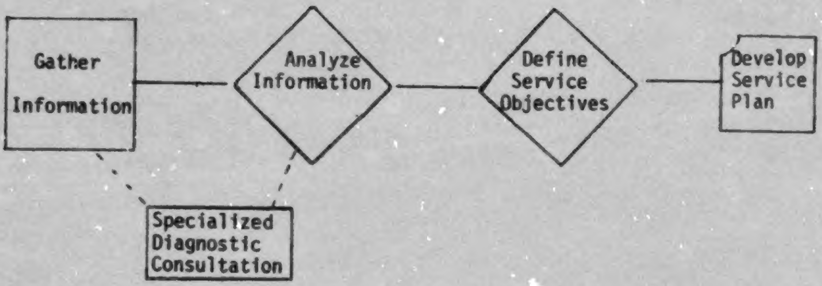
Gather Information
Analyze Information
Define Service Objectives
Develop Service Plan
Specialized Diagnostic Consultation

Figure 7. Service Planning

a) Information Gathering

The family's worker is responsible for obtaining information for developing an accurate analysis of the family's strengths and needs. However, the agency is responsible for facilitating the information-gathering process by the following means:

-- maintaining data entry and retrieval systems that give workers easy access to case records and up-to-date resource information;

-- providing timely access to professional diagnostic resources;

-- maintaining complete case records; and

-- maintaining good working relationships with other service providers including schools, courts, housing authority, police and medical and mental health facilities.

The agency is also responsible for instructing workers in professional information-gathering techniques and in sensitizing workers to the potential misuse of information.

Contacts with persons and professionals outside the immediate family must have relevance to the family's problems; must have the family's permission; and must respect the family's right to privacy.

b) Instruments for Gathering Client Data

The purpose of instruments is to collect sufficient comprehensive information about the family's (and its individuals') strengths and functioning to select appropriate treatment and service interventions and to track results. Assessment instruments for evaluation are described in Chapter IV.

c) Information Analysis

Information about the family is analyzed by the family's worker and the supervisor to determine the nature and extent of the family's needs and their individual strengths. Analysis can be systematized by separating information into the following flexible categories to help the worker and supervisor identify and organize appropriate service delivery:

1) intrafamily problems and strengths which reflect the personalities and behaviors of its members and the interactions of these individuals with one another, and

2) family and community problems which reflect the family's interactions with its external environment.

d) Specialized Diagnostic Consultations

Consultation with specialists may be necessary when problems or requirements persist and the worker does not fully understand these problems and potential solutions. The roles of specialists and consultants have been previously discussed in this chapter.

2) Family Services Component: Service Planning

Service planning involves developing service delivery objectives and a services program tailored to the family's unique needs within an appropriate time frame.

a) Service Objectives

The choice of service goals should be developed with the family and guided by the family's capability to achieve them. Unrealistic service goals and objectives confound the treatment process and exacerbate the family's problems. Goals and objectives should be time-oriented. Evaluation of achievement at the target date can be accomplished using a goal attainment technique incorporated into the agency's client data collection forms. (See Chapter IV for additional discussion of this point.)

b) Service Plan

The service plan is based on evaluation and goal formation. It includes a limited number of attainable service objectives agreed upon among the family worker, the supervisor, and the family members. The service plan is a written document that takes into account the following:

1) the assets and strengths of the family unit and its members;

2) the options, priorities and needs of the family unit and its members;

3) the clarification and definition in behavior-specific terms of what needs to change and what new skills need to be learned;

4) the identification and impact of community forces over which the family may have little or no control;

5) the opinions of expert consultants regarding medical, mental health, legal and other factors;

6) the goals of referring agencies;

7) the resources available within the agency and the community and delineation of roles and functions to bring about the specified changes.

The service plan must be fully developed and documented within thirty days of the family's entry into the system, including review and approval by the family worker's supervisor and the supervisor(s) of service units requested as resources for the family. In developing a service plan, the family's worker selects the service units required to address the family's needs and determines whether or not the service units are available. (A service unit refers to a measurable quantity of a resource;

for example, one hour of homemaker service, one hour of counseling or one psychological test.) All resources used in service planning and delivery should be quantifiable and should include units for purchased services, as well as those provided directly by service delivery staff.[6]

c) Case Recording and Documentation

The family's case record is a written document of case plan services provided, goals attained, and changes made during the family's involvement with the agency. Used by the family worker and agency as a planning and tracking document, it should be structured to facilitate the functions of family-centered services and should include demographic data, summaries of interviews and observations, summaries of prior involvements with other agencies and outcomes, and supporting reports and documents. The family record should systematically describe the worker's and family's interpretations of programs and interventions and the family members' responses to service.

3. Family Services Component: Service Provision

In the family-centered approach, the type and intensity of services will depend on the family's unique strengths and needs, assessed during the intake phase and continuously throughout the duration of services. Family-centered service providers perform recognized social work functions such as counseling, advocacy, and case coordination. However, in a family-centered service delivery system, these functions take on new meaning by incorporating the advantages of the family-centered approach. The client family and the primary worker together plan comprehensive services (often incorporating a variety of support services) which take into account the family's goals, priorities, strengths, developmental status and ecological environment. Reasonably low caseload ratios permit workers sufficient time to develop strong working relationships with their client families and to adapt services to family requirements.

The most intensive type of intervention in terms of worker hours expended, usually on a time-limited basis, is for families experiencing severe problems in several functional areas and for whom services may involve both adjustments within the family system and between the family and other systems. Service frequently involves the resources of other community agencies. Services are provided by a family service team which may include a parent aide, family therapist, and/or other consultants/specialists, who provide whatever services are agreed upon in the service design; i.e., family counseling, life skills education, parent training. Examples of other services which may be incorporated are day care, day treatment, respite care, or vocational services. The family service worker is both lead worker and service coordinator.

Most families will not require such intensive services. Assessment will suggest one or two primary areas of focus. For example, families in which the root problem is family interactions may receive time-limited family counseling/therapy, using the home setting as a base for family assessment and service delivery.

For families whose service needs are linked to deficiencies in the parents' own developmental histories, a longer period of service may be required. A trained parent aide may be employed to work with parents in the home and community and to serve as a role model. Though the length of time required for teaching and re-parenting may exceed the prescribed 3 month service period, most of the work is done by a parent aide in partnership with the primary family service worker, who often provides the counseling component of service.

Some families, who have received intensive family-centered services, may need on-going support to prevent out-of-home placement of their children. For certain families, occasional contact with the service worker may be sufficient; for others, additional supportive services may be warranted on a longer-term basis.

4. Family Services Component: Case Review and Service Program Review

The service plan is the standard against which the delivery of services and the progress of the family in achieving objectives are monitored and measured. Although the family's worker is continuously reassessing the family's needs as he/she becomes more involved with the family members, a formal assessment and review of the service program should occur periodically and prior to termination of services. Case review asks the following questions:

1) Are the services which were agreed upon being provided as planned? If not,

2) Is corrective action being taken?

3) Are services meeting the family members' needs?

4) Is specialized assessment consultation indicated?

5) Are the service objectives being achieved?

6) What are the reasons, if any, for lack of progress?

7) Does the service plan require modification?

8) Are additional services required?

9) Is termination of service indicated?

The formal case review may be conducted by the family's worker with the resource persons working with supervisory personnel, resource administrators, and the family members.

II. SECOND MODEL: THE INTENSIVE FAMILY SERVICES UNIT MODEL

Intensive family-centered services provided directly by public agency social workers are usually offered by a separate unit of trained family-based specialists. Under this arrangement, families are referred to the special unit, generally by protective services workers, when it becomes apparent that substitute placement is imminent. The caseloads in the special units are kept at a sufficiently low ratio to allow for a significant number of contact hours per family. This arrangement has proved successful in several county agencies, particularly in Minnesota.

The Intensive Family Services Unit Model is probably the simplest way to implement family-based services quickly. This model proposes the development of a service unit, parallel to existing children's services units, composed of workers trained in a family systems approach to counseling.

Referral into the family services unit might occur at varying points along the client pathway, rather than exclusively through a central intake unit as in the generalist/specialist model. For example, if the criteria for referral is imminent placement of a child or children in substitute care, then referral at any point along the client pathway is possible, as depicted in Figure 8.

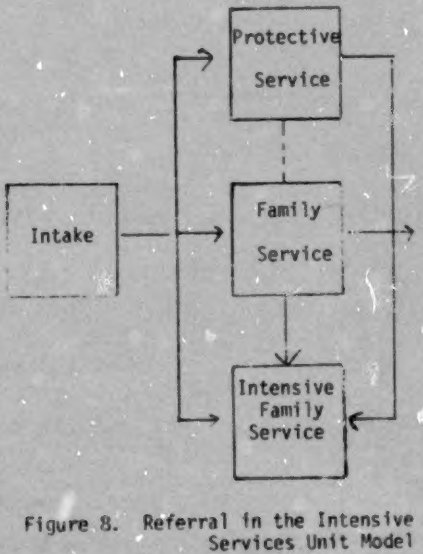

Figure 8. Referral in the Intensive Family Services Unit Model

Intensive Family Services are provided on a limited time basis. If additional treatment is required, there may be options to continue for a specified period of time, or if more limited maintenance/service is required, the case may be transferred to a worker in another unit.

The Intensive Family Services Unit Model does not preclude the adaptation of family-centered in-home services to those service units already in place. In fact, adaptation to the protective services unit in particular would likely increase the model's effectiveness by preventing further deterioration of families risking continued abusive or neglectful behaviors.

The failures in implementing this model are the result of inadequate planning prior to implementation, undefined and vague criteria for referring families to the new unit, and inadequate training and preparation of workers in the referring units. Two events have been observed: 1) workers tend to refer families that have been involved in the system for extended periods of time without problem resolution; and 2) workers in referring units pressure the intensive services unit to take more cases than can be effectively served, resulting in an over-extended new unit. Both of these situations can be prevented with careful planning prior to implementation.

Before developing a specialized unit, consideration should be given as to whether or not it is in the best interest of families to offer family-centered services only at the point when placement is pending. Family-based services is a preventive approach that should be available to families well before substitute placement becomes a consideration.

III. THIRD MODEL: THE PURCHASE OF SERVICES MODEL

After assessing the capacity of its own system and those of other community agencies to provide family-centered social services, the public agency may find it desirable to purchase all or certain components of the service design from the private sector. Examples of contractual arrangements between public and private agencies include the following:

1) purchase of intensive family-centered services for families of children dispositioned for out-of-home placement, resulting from an agency or court decision;

2) purchase of home-based, family-centered services for specific populations, such as pre-delinquents or adjudicated delinquents and their families;

3) purchase of family-centered residential or day treatment services that focus on continued parental involvement during treatment and reunification;

4) purchase of mental health and counseling services that practice the family-based philosophy;

5) purchase of training and staff development for on-going support of the family-centered services workers;

6) purchase of the services of parent aides trained to work in team partnerships with the public agency's family services workers;

7) purchase of homemakers, chore services, and respite care services as resources for public agency family services workers.

In developing purchase of service agreements, the public agency must clearly communicate its programmatic role and relationship to the provider and its expectations for services contracted.

There are several alternatives to providing family-based services using purchased services. For example, in Oregon the public agency has purchased Home-Based Intensive Family Services, primarily for families whose children are dispositioned for substitute placement. In Oregon, requirements for providers of Intensive Family Services are clearly specified in the agency contract. (A sample contract has been appended.) In Iowa, purchased services are more diverse than Oregon's and state contracts are not standardized. Time-limited intensive in-home services in Washington were originally purchased for families of adolescents in crisis and were subsequently expanded to other target populations.

The practice of purchasing core supports, such as day care and homemaker services from the voluntary sector, is common in social service agencies. For example, a district in Arizona has dedicated a portion of its foster care maintenance budget to the purchase of homemaker services from a private agency. Arkansas purchases homemaker services directly from individuals and uses personal services contracts.

In sparsely populated areas, agencies may purchase services from social workers, psychologists and other credentialed individuals to provide in-home services. This method of extending home-based services to residents of remote rural areas is being used in a Wyoming county. Similarly, the services of trained family-centered indigenous professionals and paraprofessionals can be purchased by agencies that do not currently have sufficient minority staff to provide home-based service to minority client families.

CONCLUSION

There are at least two reasons why the organizational structure of the social services agency is an important element to consider in the development of family-based services. First, the attitudes of workers are shaped, in part, by the functional descriptions of the services they fulfill. Protective services are designed to protect children from abuse and neglect. It may be very difficult for workers to assimilate the preventive and protective functions in their work with families if their job is described as protective services. On the other hand, a family services worker is more likely to view her/his role as a provider and facilitator of services to the entire family and should have less difficulty in carrying out prevention functions.

Second, service specialization may increase the probability of fragmented service delivery. It may be that the more options there are for case transfer, the more likely it will be that cases are transferred, even though a family's needs may not warrant it. Case transfers are likely to increase the probability of delays and gaps in service, and may seriously undermine the family's confidence in the agency. Service delivery systems should be designed with the client family foremost in mind.

This chapter has discussed three models for providing family-based services in the public social service agency. The chapter which follows proposes a classification system for allocating family cases to workers by needs, rather than by service descriptions.

FOOTNOTES

1. Jack C. Westman, Child Advocacy (New York: The Free Press, 1979).

2. Alfred Kadushin, Child Welfare Strategy in the Coming Years, (Washington, D.C.: Children's Bureau, 1978).

3. Ibid. p. 45.

4. For a review and discussion of recent research in the area of intergovernmental management in the human services, see Robert Agranoff and Valerie A. Lindsay, "Intergovernmental Management: Perspectives from Human Services Problem Solving at the Local Level," The Public Adminstration Review 3 (May/June 1983):227-237.

5. Gilbert Y. Steiner, The Futility of Family Policy (Washington, D.C.: The Brookings Institution, 1981), p. 15.

6. Robert Elkin, A Human Service Manager's Guide to Developing Unit Costs (Falls Church, VA: Institute for Information Studies, 1980).

CHAPTER III

A SYSTEM FOR CLASSIFYING FAMILY NEEDS

INTRODUCTION

Federal and state budget reductions, paired with increasing client demand due to high unemployment rates and economic recession, are forcing social service agencies to reexamine their priorities and, perhaps for the first time, to develop systematic methods of allocating scarce resources. Public social service agencies are under the greatest pressure since they are the last resort for many and are prohibited from turning away those eligible for services. Although various rationing schemes have been proposed, none are without difficulties.[1] With these problems in view, the National Resource Center on Family Based Services has developed a typology for the allocation of social services to families, particularly those served by public agencies. Based on the cumulative experience of private agencies which have kept seriously troubled families together in the last decade, this typology adapts the methodology of family-centered services to the public sector.

The services being reexamined grew out of a concern in the 1950s and 1960s for what was called the multi-problem family. Studies, particularly the well known St. Paul project, demonstrated that certain families absorbed what seemed to be a disproportionate share of community resources.[2] In an effort to coordinate services and to develop more efficient service delivery systems, other studies of public services were fielded.[3] These studies primarily succeeded in distinguishing the needs of elderly welfare recipients from those of younger families and in pointing out the difficulties of rendering effective social services with high caseloads in conjunction with eligibility determination. These concerns were addressed in nationwide efforts to separate individual services from family services and services in general from eligibility determination, which led eventually to the federalization of the adult programs and mandated separation of services eligibility.

While the public sector was absorbed with these organizational changes, the private sector continued to explore the area of services to troubled families. Several projects, some drawing on the rapidly developing field of family therapy, experimented with intensive services to help families under stress stay together.[4] Most featured very small caseloads (2 to 10 families), a team approach to services, and work with the family in its own home and community. Evaluations of these programs indicated considerable success in keeping families together, thereby preventing the high costs of placement.[5]

In addition, a series of research projects tested the effectiveness of "intensive" casework services with families receiving public welfare and/or classified as "multi-problem." [6] The results of these studies were not encouraging. As Geismar noted in reviewing these and other evaluative studies: "the results...support the assumption that special programs were no worse than conventional ones but do not prove that they are much better."[7] It must be kept in mind, however, that in these studies "intensive casework services" were operationalized as once-a-week to once-a-month face-to-face contacts with clients over a period of one to two years. Only the New Haven Improvement Project, one of the more successful projects, reduced caseloads to as little as 15, while caseloads in the other projects ranged from 30 to 50. Casework services were defined only by what workers did, or as one project report explained, caseworkers were given "full freedom for the use of their professional skills." [8]

Public social service agencies, while interested in developing family-centered services, have experienced several problems in adopting this approach. Mandated services mean agencies are unable to restrict access or to ensure the small caseloads necessary for intensive services. Strained budgets require the use of untrained workers and prohibit extensive in-service training. High worker turnover further frustrates continuity of services and development of worker expertise. Despite these problems, public social service agencies functioned in a relatively stable environment throughout the 1970's with adequate, if not abundant, resources.

The funding patterns which sustained public social services, however, created coordination problems by dividing service delivery into categorical units. These units typically include foster care, child protective services, adoption, adult service and family service units. As noted in the previous chapter, the primary difficulty with these categorical divisions is that clients must meet the agency's definition of service needs, rather than the reverse.

In an attempt to structure service delivery to adequately meet the real needs of families and to reflect an ecological orientation, a typology is being suggested to help differentiate the mode of services and level of effort required to stabilize each family and prevent unnecessary substitute care. The typology is proposed as the basis for a case classification methodology that will systematize the allocation of cases among workers based on the estimated hours of service required to meet client family needs in a generalist family-services structure. The typology includes five classifications: transient needs, emergency needs, limited-situational needs, multiple-problem needs, and maintenance needs.

I. CLASSIFICATIONS OF NEEDS

1. Transient needs pertains to families stranded for whatever reason in the agency's service area and who require minimal assistance to move on to their destination. It may also include casework services to migrant workers who pass through the agency's service area seasonally. Services provided by the agency are at a low level of intensity of total hours required to meet the family's needs. Coordination of community resources with advocacy and follow-up activities may be the focus of casework intervention. It should be emphasized that families are classified "transient" by their own definition. If the family members become permanent residents in the service area, the service requirements may change.

2. Emergency needs pertain to families whose difficulties are immediate, catastrophic, and are likely as not provoked by environmental factors beyond their control. The level of service required is intense and of short duration. The resources required are likely to be found in the community, rather than in the agency itself. Therefore, the agency response may be largely coordinative, e.g., identifying appropriate resources, coordinating and following up on their delivery, and advocating for community services in the family's behalf. Again, should it become evident that the family's situation requires more intensive service and the family agrees to continued involvement with the agency, another level of services may be assigned.

3. Limited-Situational needs characterize families who have begun a cycle of maladaptive interaction, which can be arrested by change in one or two areas of functioning. With concerted, time-limited efforts by the social worker and agency and community resources, they can regain their equilibrium and function independently again.

The service level may be intense initially, but is likely to result in termination of services within a short time frame. Without appropriate intervention, families in this classification tend to continue the cycles of maladaptation which are then defined as additional problems, eventually requiring longer services or resulting in family breakup. This cycle can and should be broken by immediate intervention.

4. Multiple-Problem needs characterize families that exhibit a host of problems/needs, which may include child abuse and neglect. These families require numerous agency and community resources and should receive intensive family-centered services until their situation is stabilized. Families with multiple needs have been successfully treated by private agencies using family-based interventions and often show dramatic changes as a result of intensive service.

5. Maintenance needs pertain to families who exhibit numerous difficulties of a long-standing, perhaps multi-generational, nature. Although these families are small in number, they typically absorb a significant proportion of casework hours and agency resources. If these families fail to respond to intensive services, it might be reasonable to propose that the agency's resources are being overused with little hope of successful problem resolution. Therefore, family-centered services should be limited to maintenance efforts, providing only those services required to maintain the family at a minimal level of functioning, with the goal of forestalling out-of-home placement. Of course, a crisis situation may present new possibilities of change to the family, so the option of renewing intensive services must always remain open.

II. DEPLOYMENT OF STAFF TIME

As noted earlier, the purpose of this proposed family service typology is twofold:

1) to provide a means for differentiating clients and allocating staff, and

2) to provide a means for estimating the type and number of units of resources required by the agency and the community to serve client families.

A range of options is possible in the deployment of staff time using the family service typology. The goal of family-centered services is assisting families to remain intact and to function independently. Therefore, worker time and agency resources must be optimally deployed in order to achieve this goal. A review of the typology indicates that agency resources should be concentrated on two classifications, limited-situational needs and multiple problem needs, primarily because families in these classifications are at risk of imminent dissolution with consequent placement of their child(ren) in substitute care arrangements. Concentrated and intensive efforts must be made by the agency to prevent these events from occurring. Intensity is measured here by the number of casework hours and units of supplemental or support services expended per client family. We hypothesize that the level or degree of intensity will be greatest for multiple-problem needs and slightly less for limitedsituational needs.

The remaining classifications should absorb fewer agency resources. Families in the emergency services classification will require high intensity services, but the period of time during which these services are provided will be of short duration. Maintenance services for families, who are likely to require help over an indefinite period of time, should be provided only to maintain a minimal level of functioning, unless a crisis situation appears to open the family to significant change. Finally, transient families are likely to be small in number in most public agencies. Although a transient family's service needs may be numerous, the agency's responsiblity is to help them with their immediate needs and to return to their place of residence or their next destination. The degree of intensity in terms of service hours expended by classification is illustrated in Figure 9.

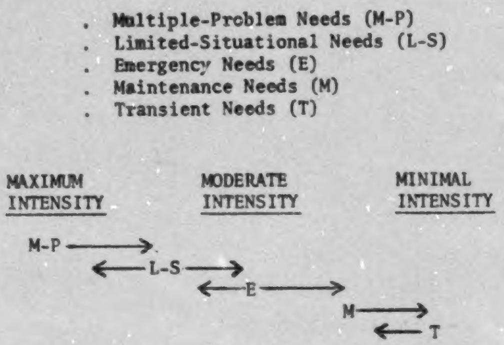

Figure 9. Degree of Intensity in Terms of Service Hours Expended.

III. CRITERIA FOR CLASSIFICATION OF CASES

The typology is based largely on experiential information and the classifications may be collapsed or broadened, based on an agency's defined service population. Similarly, the criteria for assigning a given case or class of cases to a classification should be established by each agency using the information in its own case records. The summary description of a suggested methodology for establishing criteria for case classification is as follows:

Phase I

A group of experienced child and family services supervisors review a randomly selected sample of active cases across child-serving units. Through group process, supervisors identify primary or root problem(s) that may be central to each family's difficulties and that can be addressed either directly or in coordination with other community services providers. Based on problems identified and group consensus, cases are then assigned to either "limited-situational needs" or "multiple-problem needs" classifications. The criteria used for assignment of cases to each classification is then identified and documented by the group.

Phase II

Estimates of the total caseworker time required to address the social work needs of families by classification may also be made by the group. The resulting criteria and time estimates may then be used over time by the intake and family services supervisors to test their validity and utility.

The same methodology may be used to establish the criteria for maintenance needs. However, this classification needs to be thought through carefully by staff specialists and the agency's administrators since the tolerance level of communities demanding active service interventions for certain families will vary.

Both the emergency needs and transient needs are self-defining and criteria for recognizing cases in these classifications should be relatively easy to construct.

CONCLUSION

It should be possible to develop a scheme for allocating cases to supervisory, caseworker and paraprofessional staff, using a family typology that is sufficiently broad to encompass virtually all current and potential family clients. The next step must be to develop model formulations that, by assigning weights to each classification, guide administrators in the equitable allocation of staff time and in job design. With a careful analysis of data obtained from the agency's past and current client files, it should also be possible to discern which resources (support programs in and outside the service agency) are most frequently required for the stabilization of families in each of the five classifications.

There are a number of staffing models that can be used to allocate social work personnel in the family-centered services scheme. However, the first task is to estimate the units of service required to provide the level of intensity prescribed for each classification. Distinctions should be made for units of time in direct contact with the family and its individual members, units of time spent in collateral contacts, and units of time in the execution of administrative and supervisory tasks, and units of time spent in transit (e.g., to and from the family's home, shcools, clinics, etc.).

The next task is to examine how services in the five classifications are integrated into the service delivery system design. For example, the Generalist/Specialist Family Services Model described in Chapter II, is composed of two core components (intake and family services) and at least four core support services (day care, parent aide, foster care, and adoption) provided either directly by the public agency or purchased from private, voluntary agencies in the community.

Emergency and transient classifications can be provided directly by the intake unit. The remaining classfications, after initial assessment by the intake unit, are transferred to the family services unit. It is important that families with "limited-situational needs", "multiple-problem needs", and maintenance needs" have the opportunity to develop and maintain a relationship of trust with a primary worker. Thus, movement between these categories should reflect only an increase or decrease in service units, not a change of workers. Should out-of-home placement become necessary, the same worker should remain with the case, working toward reunification, or in cases which lead to termination of parental rights, toward selecting an appropriate adoptive family and smoothing the child's transition into the new home.

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CHAPTER IV

ADMINISTRATORS' GUIDE TO CLIENT NEEDS ASSESSMENT

INTRODUCTION

Definition

Assessment is a process of collecting and analyzing information for service planning and delivery by the service worker and client family partnership.[1] The term "assessment" is used frequently in social work and has various definitions. The National Resource Center identifies three levels of client assessment, each of which is discussed later in this chapter: assessment at intake, ongoing assessment, and assessment of client outcomes.

In family-centered assessment, transactions with many elements of the family's ecology are included.[2] Family-centered assessment begins with the client family's goals and priorities. Practitioners take seriously the adage that family members are really the best source of information about the family.

Early and accurate assessment is crucial for purposes of differential diagnosis: distinguishing those families for whom family-based services is not appropriate from those for whom family-based services has been most effective. In times of diminishing resources, it is important that social service agencies make optimum use of available funds. There is understandable concern among child welfare workers that the movement towards maintaining abused and neglected children in their own homes is growing, while funds for in-home supportive services and social services in general are being reduced.[3]

There are families for whom the time required to bring about needed changes, the poor prognosis, and degree of risk to the child(ren) are such that family-based service would not be the most appropriate service plan. Materials are now available to aid workers in making an assessment based on multiple indicators rather than just one factor.[4] For example, mental retardation of parents is not sufficient to warrant removal of children from the home. However, if a child's parents are mentally retarded and cannot care for themselves and further deny that a problem exists and refuse services, these multiple factors suggest a risk to the child sufficient to warrant removal from the home.

There are families for whom family-based services are not likely to be effective within the required time limits, but such families are likely to be few in number. There are many more families with serious problems for whom research indicates that intensive family-based services are effective, including families in which child abuse, sexual abuse, failure to thrive, or chronic neglect has occurred.[5]

I. ASSESSMENT AT INTAKE

Intake (also discussed in Chapter II, pp. 29-30) is the point at which the individual or family comes into contact with the social service system. Accurate assessment at this point is necessary for ensuring effective service delivery.[6] Accurate assessment means that clients' problem areas and strengths are identified and that they are referred to the unit (or outside agency) that best meets their needs.

The assessment function at the intake phase, therefore, is crucial. Intake workers need to be skilled in interviewing, knowledgeable about community and agency services, family systems theory, perceptive in identifying and capable of handling immediate needs, and sensitive to values and behaviors of minority group members.

Using the prototype of family-centered services and the family typology presented in this manual, the intake unit performs several important functions. It screens out child protective service calls and refers them to the investigative personnel, identifies transients and clients with emergency needs, and deals with such cases according to agency policy, knowledge of community resources, and crisis intervention principles. In addition, the intake worker evaluates the needs and strengths of clients seeking help and determines where a case should be referred (to the family service unit or another community agency). With accurate assessment, cases can be allocated to family service unit workers on the basis of how much worker's time they will require.

At the first point of contact between client and agency, the intake worker begins to build a positive relationship with the client. By maintaining an atmosphere of openness, acceptance, and willingness to hear the client's concerns, the worker helps create an attitude of hopefulness and a basis for trust. Many social workers believe that the worker/client relationship is the most significant predictor of service effectiveness.[7]

It is particularly important for intake workers to be knowledgeable about and sensitive to the values and behaviors of minority group members in the community. If a strong worker/client relationship is to develop, workers will have to win the confidence of minority families that have suffered from institutionalized racism in the social service system. The administrator's role is to ensure that intake staff are trained in working with minority families and to fill vacant intake positions with representatives of minority groups in the community whenever possible.

Collecting and Evaluating Information for Intake Assessment

In the assessment process, the worker collects information about (and with) a client family in order to evaluate the family's needs and develop a service program. The information gathered should reflect a systemic orientation -- that is, it should seek to understand the family as a system of interacting members involved with other community systems. Therefore, information will cover a wide range of areas including: family composition and demographic data, material needs, familial relationships and strengths, developmental progress including the physical and emotional status of individual family members, the family's involvement with community systems, and out-of-home placement history.

The information gathered should also be relevant to the client family's current situation and problem areas, and of potential use in service planning.[8] The object of collecting information is not to create lengthy case records, but to understand the family's problems and strengths and put this information to use.

There are six basic methods of collecting such information:

- interviewing (family members, individually and together);
- observing (the family at home and in community, intrafamilial interactions, the child at school);
- examining written materials (case records, court and school reports);
- making collateral contacts with other agencies with whom the family is involved (with family's consent);
- administering psychological tests, and
- employing data collection instruments.

Accurate assessment is best achieved through several methods of information gathering, rather than one.[9] Intake workers, therefore, need to have time for field work as well as office work. Observing a family in the home environment, rather than the agency office, yields much useful information about the family's functioning.[10] The intake unit should be structured to provide sufficient time for workers to interact with each family in its ecological context.

The first four methods listed above are familiar to social workers and need little elaboration. Social workers are accustomed to using these techniques and preparing narratives synthesizing the information acquired. High caseloads and time constraints, however, have often resulted in a heavier reliance on reading case records and conducting in-agency interviews than on interviewing and observing families in the home setting.

Psychological tests may be useful if the intake worker feels the information is necessary for an accurate assessment. These tests are most informative if the worker poses specific questions to be addressed rather than requesting "a psychological" (evaluation). Asking specific questions of the consultant will make the tests more relevant to the client's problem areas, as well as less costly to the agency. 11

Data collection instruments prepared by the agency or developed and tested by social researchers can be valuable tools for managing massive quantities of information from family-based assessment and for structuring the complexity of families reviewed. Because of the discipline's long tradition of reviewing families from a problem orientation, it is particularly important to use instruments which condition workers to identify strengths and "think systems." The data collection instrument organizes the information obtained through interviewing, observing, reading written materials, and consulting with other professionals involved with the family.

Of course, the choice of information collection instruments depends upon the purpose for which information is collected. First, each instrument considered by an agency should be analyzed for its direct and indirect effects on the workers' attitude toward families and on the workers' attempts to move from traditional "cause and effect" thinking to a systems orientation.

Also one data collection instrument can often replace a number of other forms used by the agency, thus alleviating some of the burden of paper work which befalls the social worker. (See Figure 10, at the end of this chapter, for a summary of data collection instruments described in the following pages.)

Assessment-of-needs instruments may be used at the intake level for decision-making in determining level of risk for protective purposes, in allocating cases to appropriate service units, and in choosing, at least initially, the optimal mix of services required to meet a family's needs. Below are descriptions of two examples of assessment-of-needs instruments.

1. Illinois Child Abuse and Neglect Investigation Decisions Handbook

The Illinois Department of Children and Family Services has developed a decision-making matrix for Child Protective workers, designed to indicate the degree of risk to a child who is the subject of a protective services investigation. The matrix consists of twelve factors (Child's Age, Child's Physical and Mental Abilities, Caretaker's Level of Cooperation, Caretaker's

Physical, Mental and Emotional Abilities/Control, Rationality of Perpetrator's Behavior, Perpetrator's Access to Child, Extent of Permanent Harm, Location of the Injury, Previous History of Abuse/Neglect, Physical Condition of the Home, Support Systems, and Stress) with descriptors of low, intermediate and high risk. If five of these factors are rated at the high risk level, it is suggested that risk to the child is sufficient to warrant emergency intervention. This instrument is useful in assessing the level of risk to the child and thus the appropriate interventions to ensure the child's safety.

2. Eco-map

The eco-map has been useful as a family assessment tool, particularly in the early stages of intervention. Eco-mapping enables the worker and family to learn about the family system and its interactions with the environment through a diagramming process. Circles representing the client family and other significant systems in the community (place of employment, school, church, extended family, friends) are drawn and form the basis for discussion between worker and client family about the relationships between family and community systems. Information obtained through this process leads to an understanding of the family's problems, strengths, and desired goals. The informality of this tool often enhances open interchange between client family and worker and reduces the awkwardness of discussing intimate information with an unfamiliar person (the social worker).

II. ONGOING ASSESSMENT

Although the initial assessment at the intake stage forms the basis for service delivery, assessment remains a dynamic process. As the family and service worker enter a service contract, the worker's hypotheses about the family will change for several reasons:

- new information will emerge as the worker gets to know the family better and a stronger sense of trust develops;
- interventions by the worker will cause changes in the family and community systems;
- concerns of family members change because of their interactions with other social systems and as they accomplish their own "life tasks."

Workers must be observant of such changes in the family, continually reassessing and revising service plans and interventions with the family accordingly.

Assessment-of-Change Instruments

Assessment-of-change instruments may be used to chart the changes that occur at the functioning level of the family and its individual members over time. Instruments assist workers in recognizing and validating even small increments of change that enhance family esteem, provide accurate data for court reporting, and promote worker satisfaction. Measurements of change may be used to evaluate service interventions and degree of intensity, in terms of units of service expended, of a given service type.

Below are descriptions of four examples of assessment of change instruments:

1. Guidelines for Rating Levels of Social Functioning

This instrument provides a seven point "rating" (from inadequate to adequate) on numerous aspects of family functioning. For each item to be evaluated, a description of what constitutes inadequate, marginal and adequate performance is offered. There are nine major headings, each containing several specific items: Family Relationships and Family Unity, Individual Behavior and Adjustment, Care and Training of Children, Social Activities, Economic Practices, Household Practices, Health Conditions and Practices, Relationship to Social Worker, and Use of Community Resources.

The ratings are used to determine the primary problem areas that warrant intervention and to measure family change over time. Those items which are rated "inadequate" are ones posing a potential threat to the children's well-being. This instrument is geared to assessment of the family as a whole and does not document the problems of individual children in the household.

2. Level of Family Functioning

The LOFF scale is designed to rate families over a range of problem areas that indicate degree of risk of family separation. There are ten areas of functioning: Finances, Employment/Employability, Housing, Physical Health, Family Mental Health, Use of Addictive Substances, Education, Parenting Skills, Support Systems, and Community Participation, and a varying number of items in each. The five point rating scale is designed to yield a high score for families at a high risk of separation.

Workers need to be trained in using the rating scale if it is to be reliably implemented. The instrument can be used to assess changes in family functioning over time and the coding schema makes it easy to use for research purposes. The focus of the scale is the family as a unit, rather than individual family members. A revised version of the LOFF is currently being developed.

3. Child Welfare League of America - Child Well-Being Schedule

This instrument documents changes in the caretaking environment of children referred to protective service agencies. It consists of a face sheet requesting demographic information about the family, with the remaining pages requiring a rating on forty-three different aspects of family functioning and individual children's well-being. For each item, a description of the possible ratings is provided, and the worker is asked to explain why a certain rating was selected in every item. This rating scale can be applied at established time intervals to measure change in the family and child well-being.

4. Jefferson County, Colorado Department of Social Services - Goal Attainment Scale

The Intensive Treatment Team Project of the Jefferson County Department of Social Services utilizes a goal attainment scale to evaluate client families' progress in five areas of family functioning: Family Stability, Intimate Adult Relationships, Individual Functioning, Parent-Child Realtionships, and Social Isolation. Client family and therapist together develop behaviorally specific and time-limited goals in each of these five areas. Clients' active participation in setting their own goals is believed to enhance client self-determination and create a stronger motivation for change. Progress is monitored at scheduled time intervals for achievement of each goal, using ratings of "at goal", "above goal", or "below goal".

III. ASSESSMENT OF CLIENT OUTCOMES

The term 'client outcomes' can refer to numerous measures: client satisfaction with services received, the client's situation upon termination of services or the client's status at a period of time after termination (usually three months to one year). Client outcome measures may be obtained in several ways: through interviews with or questionnaires mailed to clients, from caseworkers' reports/observations, or through trained observers.

Because of the variety of interpretations and methods of obtaining this measurement, 'client outcomes' can be a confusing term. In defining client outcomes and choosing or devising a data collection instrument, agency administrators must decide specifically what they would like to measure, the purposes for which this information will be used, and the most effective means of obtaining the outcome measure (including a consideration of costs and time required).[12]

In a survey of child welfare agencies, Magura and Moses found that most outcome information was obtained by agencies at the time of case closing. A follow-up of clients within six months or more after closing occurred less frequently.[13] While an assessment of family functioning at the time of case closure can provide a measure of service effectiveness, it reveals nothing about the lasting gains from service. It can be argued, however, that the agency's only legitimate concern is the family's status at the time of closure and that longer term follow-up would constitute invasion of the family's privacy.

Assessment of Client Outcomes Instruments

Following are four examples of assessment of client outcome instruments. Although these instruments can also assess client change, they are listed here because they do allow for a measure of family functioning at the time of case closure.

1. National Resouce Center on Family Based Services

The National Resource Center developed a series of instruments for use in a pilot family-based service project. The instruments include a baseline data form, monthly data form, outcome data form (each two pages in length), and a monthly time sheet. The face sheet on all three data forms contains demographic questions, previous service history and child placement history -- consolidating several forms to prevent duplication of information. The second page contains questions relating to family functioning, problem areas, and service needs. The monthly time sheet is a record of all service hours provided to a client family in a given month, broken down into categories such as direct service hours, purchased services, transportation, paperwork, etc., the purpose of which is to determine the costs of services provided to each family. The instrument is designed to measure family change from start to termination of services and requires minimal time to complete.

2. Virginia Pre-Placement Preventive Services Project

The Virginia Department of Social Services has developed a set of evaluation instruments (Family Baseline Date, Monthly Status Report, Family Outcome Data) for use in the state's preventive services projects. The Baseline form collects information on family composition, presenting problems, services received by the family, and includes a level of family functioning scale. The scale is an adaptation of the Child Welfare League of America's Child Well-Being Schedule discussed above. The Monthly Status form records changes in residence for at-risk children and services received during the month. The Outcome Data form includes family composition information similar to the baseline form, family problems, questions about the caseworker's perception of the family's changes from services, and the level of family functioning.

This set of evaluation instruments measures changes in family problems and the functioning level from intake through termination. It also allows for evaluation of services received by the family over time (type of services, number of hours).

3. Chesapeake, Virginia - Durham, North Carolina - Urban Institute Client Outcome Questionnaire

Designed as a structured interview (in person or by telephone), this questionnaire can be used at the start of services, follow-up, or both. The questions are organized into the following sections, some of which may be deleted if desired: background information, client satisfaction, physical health, performance of activities of daily living, mental distress, family strengths, quality of substitute care, child behavior and parenting, alcohol and drug abuse, physical abuse, economic self-support and security. Despite the length (thirty-five pages), the interview format is not difficult to administer.

4. Oregon Intensive Family Services Questionnaire

The state of Oregon devised this eight-page questionnaire for evaluating the Intensive Family Service projects. The focus is the family as well as the child who is at risk of out-of-home placement (those eligible to participate in the IFS project). The questions, all of which are closed-ended, include demographic information about the family, family and target child characteristics and problems, and information regarding child placement that may have occurred during the course of treatment. The questionnaire is completed within ten days after the family's termination from the IFS program.

CONCLUSION

The concept of assessment has a number of different meanings among social work practitioners. In this chapter, three levels of assessment were identified: assessment at intake, ongoing assessment, and assessment of client outcomes. The data collection instruments described do not prescribe service plans. Rather, their usefulness is in organizing information about a family, suggesting what the primary problem areas might be, and indicating changes in the family during the course of service. It is the worker's function (using these instruments as guides) to put this information to use with the family in developing and carrying out the service program, and the administrator's function to use this information for program evaluation.

Title	Focus	Availability
Illinois Child Abuse and Neglect Investigation Decisions Handbook	Assessment of need	Illinois Department of Children and Family Services 1 N. Old State Capitol Plaza Springfield, IL 62706
Eco-map	Assessment of need	Ann Hartman School of Social Work, Univ. of Michigan 1015 E. Huron Ann Arbor, MI 48104
Guidelines for Rating Levels of Social Functioning	Assessment of change	Ludwig L. Geismar, *Family and Community Functioning* (Metuchen, NJ: The Scarecrow Press, Inc., 1980).
Level of Family Functioning	Assessment of change	Barbara Jameson Social Science Research Associates, Inc. 1205 W. Main St., Suite 209 Richmond, VA 23220
Child Well-Being Schedule	Assessment of change	Stephen Magura Child Welfare League of America 67 Irving Place New York, NY 11103
Goal Attainment Scale - Jefferson County, Colorado	Assessment of change	Jefferson County Department of Social Services 8550 W. 14th Avenue Lakewood, CO 80215
National Resource Center - Assessment Instruments	Assessment of client outcomes	National Resource Center on Family Based Services School of Social Work - University of Iowa N118 OH, Oakdale Campus Oakdale, IA 52319
Virginia Pre-Placement Preventive Services Project	Assessment of client outcomes	Norman Christensen Monitoring & Evaluation Virginia Department of Social Services 8007 Discovery Drive Richmond, VA 23288
Chesapeake, Virginia-Durham, North Carolina-Urban Institute Client Outcome Questionnaire	Assessment of client outcomes	The Urban Institue, *Developing Client Outcome Monitoring Systems* (Washington, D.C.: The Urban Institute, 1981).
Oregon Intensive Family Services Questionnaire	Assessment of client outcomes	Roland Hartley, Oregon Dept. of Human Resources Children's Services, 198 Commercial St. S.E. Salem, OR 97310

Figure 10. Summary of Data Collection Instruments

FOOTNOTES

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3. Kathleen Coulborn Faller and Ellen M. Tickner, "Permanency Planning with Scarce Resources: The Necessity of Mental Health - Legal Collaboration," Ann Arbor: University of Michigan Interdisciplinary Project on Abuse and Neglect, (1982), p. 1.

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6. Harriet Goldstein, "A Parenting Scale and Separation Decisions," *Child Welfare* Vol L:5 (May 1971):271-6.

7. Enola K. Proctor, "Defining the Worker-Client Relationship," *Social Work* Vol. 27:5 (September 1982):430.

8. Eileen Gambrill, Casework: *A Competency-Based Approach* (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1983), p. 31.

9. Allen Pincus and Ann Minahan, *Social Work Practice: Model and Method* (Itasca, IL: F.E. Peakcock Publishers, Inc., 1973), p. 134.

10. Mary Larkin Bloom, Usefulness of the home visit for diagnosis and treatment," *Social Casework* (February 1973):67.

11. Kathleen Coulborn Faller and Ellen M. Tickner, pp. 2-3.

12. For a fuller discussion of client outcome measures, see *Developing Client Outcome Monitoring Systems: A Guide for State and Local Social Service Agencies* (U.S. Dept. of Health and Human Services, Office of Human Development Services Grant #18-P-00317/01, September 1981).

13. Stephen Magura and Beth S. Moses, "Outcome Measurement in Child Welfare," *Child Welfare* 59:10 (December 1980): 595-606.

CHAPTER V

PERSONNEL UTILIZATION FOR FAMILY-CENTERED SERVICES

INTRODUCTION

There are no simple solutions to the complex problems facing public social services administrators in today's constrained economic environment. For a system to function effectively, whether its goal is the production of widgets, or service to dysfunctional families, the inputs must not exceed the capacity of the system to process them. Unlike the widget factory, which either makes favorable adjustments to economic constraints or is forced out of business, the public social service agency is guaranteed continued existence by statutory authority, and must make adjustments to economic constraints without violating the legal requirements of its public trust. And yet, the inputs for many public agencies (client families with serious problems) are exceeding their capacity to cope.

In order to deal with a steady or increasing flow of client families, a reasonable allocation of worker time and a flexible schedule, which permits workers to be available when families need them, are necessary.

This chapter will discuss time allocation and caseload ratios for workers and how these factors affect job classification and collective bargaining.

I. WORKER TIME ALLOCATION

The criteria on which the development of caseload standards is based are illusive. Although prescriptive standards are commonly set by state agencies, legislatures and the courts -- as in Lynch v. King[1] and G.L. v. Zumwalt[2] -- the basis for their formulation is not clear. Attempts have been made to rationalize the allocation of cases to workers, such as with the development of case weighting systems in Iowa and Arizona. In these systems, weights are assigned to tasks and service types, and workers accumulate points up to a prescribed level within a prescribed range. There are difficulties with weighting schemes of the types used in these states. They appear to err in an effort to be precise, making them cumbersome to use. They are also "worker-driven" and subject to manipulation. However, attempts so far to create a rational system for time, and by implication, case allocation, indicate a desire to bring science to the management of social services.

Before a worker time allocation system can be developed, the administrator may wish to clarify the service goals of the agency's child and family services delivery system. This may not be as simple as it sounds. For example, does the agency define its role or mission as that of broker of services in the community, i.e., is the worker's role that of coordinator of services for client-families? Or, is the agency's goal to provide direct services and are workers expected to be on the front line of service delivery? Are workers expected to perform clinical tasks such as counseling and family therapy?

If the majority of the line worker's time is case management, i.e., coordinating and monitoring services delivered by other community-based agencies, the worker's time may be allocated with greater precision. However, if workers are expected to perform clinical tasks, the time allocations are then subject to numerous variables that can, perhaps, be estimated within probable limits.

The social worker's time may be divided into two general categories: fixed and variable. Fixed tasks are those which are routinely performed by a class of workers and which may or may not relate to casework, such as SRS forms, staff management and training. Variable tasks are those performed in behalf of client families and are determined by the family's needs. Fixed tasks can be measured and the percentage of time expended in these tasks can be estimated. The remaining time is presumed to be spent on the variable tasks associated with family casework and measurement may be less precise.

An attempt has been made to differentiate the needs of families for services with the development of a five-classification typology, discussed in Chapter 3. Three of these classifications and several variable tasks, not mutually exclusive to a single classification, may be performed by the social worker to meet the needs of families. These are depicted in Figure 11.

Classification	Variable Tasks
Limited-Situational Needs	Counseling/Problem Solving Resource Coordination
Multiple-Problem Needs	Family Therapy Skill-building Resource Coordination
Maintenance Needs	Counseling/Problem Solving Client Advocacy

Fig. 11: Examples of Variable Tasks Associated With Family Typology Classifications

II. MEASUREMENT OF VARIABLE CASEWORK TASKS

The projected units of service required for a given family may be estimated on the basis of need, using the classifications in the family typology (Chapter 3). Both worker caseloads and units of core and core support service can be estimated based on the range of expected hours per client.

While time limitations on categorical services are not generally implicit, the reverse is proposed for family-centered services. Some flexibility is necessary. However, the experiences of family-centered programs in Oregon and Minnesota indicate that results are attainable in the majority of cases within estimable time frames. Assuming flexible time constraints on the provision of family-centered services, the agency can reduce the worker caseload and still handle the same number of cases per year.[3]

Acceptable caseload ratios can be achieved without sacrificing family-centered service requirements, if cases are differentiated according to the level of intensity and hours of service required. For example, a family services worker might be assigned a maximum of three new multi-problem families at any given time. The remainder of his/her caseload would consist of families requiring considerably fewer hours of worker time for problem resolution.

For those agencies not required to maintain uniformly consistent caseload ratios, cases can be grouped according to level of intensity of hours required so that a limited number of caseworkers carry a small number of difficult cases, while the remaining workers carry proportionately higher numbers of less problematic cases.

III. JOB CLASSIFICATION AND COLLECTIVE BARGAINING

Implementation of family-centered services in organized social service agencies need not pose insurmountable problems if employee representatives are encouraged to participate throughout the planning and implementing process.

Family-centered service provision is associated with increased worker satisfaction and professionalism, both recognized goals in collective bargaining. Job satisfaction and professionalism are background issues at the bargaining table since bargaining is concerned primarily with wages, hours, and other terms and conditions of employment. Family-centered services issues include flexible hours for social workers to accommodate the other than nine-to-five needs of client families and, perhaps, equity in hours expended rather than equity in caseload ratios. Management trade-offs may involve an upward classification of family-services workers as a group (Example: Caseworker II promoted to Caseworker III), decreased paperwork with the addition of case-aides assigned to form-completion and related responsiblities, and increased flexibility in overtime remuneration or compensation.

Since the number of hours worked per week and compensatory time or pay for overtime worked are issues in collective bargaining, and are generally specified in the union contract, a method for meeting collective bargaining demands, as well as client needs, is required. A suggestion for meeting this dual requirement has been proposed by the University of Iowa Labor Center. The concept is called the extraordinary work week.[4] This concept redefines the work week from the traditional Monday through Friday to Monday through Sunday. It incorporates a minimum reporting time feature, which may be four to six hours per day during the traditional work week. Workers may be required to work a minimum of thirty-five hours and a maximum of forty hours. An hour-and-a-half compensatory time is guaranteed for every hour worked over forty hours. A ceiling may be placed on the number of acceptable compensatory hours, substituting time-and-a-half pay beyond the designated ceiling.

During regularly scheduled, periodic staff meetings, caseloads are reviewed and stabilized. For example, if one or more workers are consistently working beyond the forty hour maximum work week or at thirty-five hour minimum work week levels, adjustments may be made to equalize caseloads. An example of the extraordinary work week schedule is depicted in Figure 12 below.

Week 1

	M	T	W	Th	F	S	S	
Hourly minimum	4	4	4	4	4	0	0	Worker works 42 hour week
Additional hours expended	* 3	4	2	4	4	5	0	Agency owes worker 3 hours compensatory time
Total	7	8	6	8	8	5	0	

Week 2

	M	T	W	Th	F	S	S	
Hourly minimum	4	4	4	4	4	0	0	Worker works 32 hour week
Additional hours expended	** 1	2	4	3	1	0	0	Worker owes agency 1 hour to be made up the following week
Total	8	6	8	7	5	0	0	

*can be worked any time in the 24-hour period
**plus 3 hours compensatory time

Figure 12. Extraordinary Work Week

Any alteration in the work week under current contract will require a renegotiation between the union and administration. If the current contract does not expire for some time, a test period utilizing the extraordinary work week, perhaps in a single unit, may be implemented with the provison that it be reviewed immediately at the request of either the union or the agency administration. If the test is successful, the revised work week may then be included as part of the next collective bargaining process.

CONCLUSION

An essential element in operationalizing family-centered social services is a rational system for allocating worker time. Workers must have sufficient time to attend to the range of needs of client families within prescribed limitations and at times when families most need services. This is a tall order in today's economic climate, particularly when decreased funding for staff and hiring freezes preclude the addition of new social workers. Given these limitations and a steady or increasing flow of clients into the system, it becomes necessary to find solutions that do not reduce the quality of services or violate the legal mandate of the agency to provide for families' needs.

When faced with enormous caseloads and burdensome paperwork, workers will select clients to whom they can respond. Unfortunately, the selection process may be flawed. Therefore, it is suggested that administrators systematize case selection using a typology based on client need and estimated service requirements (units of service). A suggested framework and process for developing criteria for allocating cases, based on service needs, is discussed in Chapter 3.

In addition to rational case allocation, the delivery system must permit social workers to respond to families within the family's time frame and compensate workers for time expended. Flexible work schedules may be accommodated even under collective bargaining constraints if management makes reasonable efforts to compensate or remunerate workers. The extraordinary work week concept is suggested as a means for providing flexible scheduling under these circumstances.

FOOTNOTES

1. Patricia Lynch, et. al. vs. Edward J. King et. al., U.S. District Court, District of Massachusetts, Civil Action No 78-2152-K, September 20, 1982.

2. G. L. vs. Zumwalt, U.S. District Court for the Western District of Missouri, Western Division, No. 77-0242-CV-W-4, filed March 21, 1983.

3. The state of Oregon found that by limiting the duration of intensive services to 35 hours over a 90-day period, and maintaining caseloads of 8-9, more families were helped over a 12-month period than over the same period prior to implementaion of intensive family services.

4. Gene Daniels, Program Consultant, University of Iowa Labor Center, in an interview, December, 1982.

CHAPTER VI

A COMPARATIVE ANALYSIS OF THE COSTS OF SUBSTITUTE CARE AND FAMILY-CENTERED SERVICES

INTRODUCTION

One of the goals of family-centered services is to prevent client dependency on the social service agency. To accomplish this goal, worker expertise and community resources are concentrated on early assessment and intervention, accelerated problem resolution, and termination or disengagement. Intensive, time-limited service intervention requires that the agency commit substantial worker time and supportive service resources at the point of intake and during ensuing weeks. Theoretically, the number of resource hours expended declines over time as the family takes greater initiative for problem-solving. Disengagement or time-limited maintenance may occur within three to nine months.

Family-focused service delivery should result in decreased substitute care expenditures, thus permitting the diversion of savings to strengthening family-based service resources. The National Resource Center on Family Based Services has compiled information on a range of programs which serve children and their families in their homes. Most of these programs are operated by private agencies, although some data is available on public agencies that have developed family-centered service components. Comparisons among all of the programs known to the Center indicate considerable variation in style and approach. However, all seem to advocate the family unit as the focus of service delivery.

Comparisons among programs also reveal considerable differences in reported costs associated with service delivery. These variations may be attributed to factors such as the number of casework hours expended per client family, staffing patterns, salary differentials and the accounting and data collection methods used. However, all programs report significant results in preventing substitute care placements for the children of families served. Table 1 illustrates the range of expenditures per family and the percentages of children prevented from substitute care placement reported by four family-based services programs in different geographic locations.

TABLE 1

SERVICE AND COST RESULTS: INTENSIVE FAMILY BASED PROGRAMS

FAMILIES West Branch, IA	5 mo.	$4,000	91%
Homebuilders Tacoma, WA	6-8 wks.	$ 1,769	92%
Intensive Family Support, Hillside Children's Center Rochester, New York	6-7 mo.	$ 1,338	88%
Oregon Intensive Family Support	90 da.	$ 1,000	92%

Although local programs around the country report success rates of 80% and above in prevention of substitute placements, such programs have been critically reviewed and found to be lacking empirically validated measures of performance. It appears, however, that since one objective of family-based services is to prevent the placement of children in substitute care, valid measures of performance are a reduction in proportionate placements and a decrease in expenditures associated with these placements. Most prevention programs compare the actual expenditures per family for alternative services with the potential cost if all the children referred for service had been placed. Estimated savings are computed on weighted averages for actual placements occurring in the same jurisdiction, or on the basis of the "best professional judgment" of the referring worker as to whether the child would have been placed had the family not received family-centered services.

The essential difference between family-centered services and foster care services expenditures is placement maintenance costs. Since family-centered services initially require a greater commitment of worker time and support services than foster home services, it would appear that per client expenditures would be higher than foster care services expenditures even when monthly maintenance costs are included. However, when projected substitute care costs are discounted over the average length of time a child is likely to remain in care, family-centered services are more cost efficient.

I. FEDERAL FINANCIAL PARTICIPATION (FFP) AND FAMILY-CENTERED SERVICES

Since public agencies generally rely on federal grants to finance portions of their child welfare programs, analyses of family-centered and substitute care costs must take into account both the sources of program revenue and the percentages of matching funds requisite to federal financial participation (FFP).

For example, child foster care expenditures for maintenance in foster family homes, group homes and institutions, and for associated social services are funded by Title IV-B, Title IV-E, and state and local monies. Certain related program expenditures are funded by Title XX (Social Services Block Grant) and Title XIX (medical assistance). Social services are reimbursed through Title IV-B and Title XX with specified FFP according to the particular title and program.

The federal contribution under Title IV-B is 75%; the remaining 25% is paid by the state. (Some states require that localities participate financially in the state's match.) Under Title IV-E, the federal share for foster care maintenance payments is equal to the federal medical assistance percentages, with a 75% rate for training and a 50% rate for other administrative costs. Up to 10% of social service funds (SSBG) may be transferred to other block grants such as preventive health and health services, alcohol and drug abuse, mental health services, and others -- and vice versa.

Funds not needed under Titles IV-E foster care may be transferred to Title IV-B if the state meets the requirements of section 427(a), with certain limitations as to the amount of transferred funds, and if federal appropriations do not reach the "trigger" amounts under Title IV-B ($266 million in FY 84).

Options to transfer funds may permit administrators to direct certain services resources to train new and existing foster care and protective services workers in family-centered services skills, or to purchase intensive family-centered services from the voluntary sector. If states are expending funds from general revenues on maintenance of non-ADC eligible children, projected savings from the diversion of new children coming into care can be used to match local expenditures for family-centered services, thus providing an incentive to local agencies to develop family-centered prevention programs.

II. SUMMARY COST ANALYSIS

The following analysis is based on figures supplied by a state division of social services. It is a prospective analysis in that it attempts to project expenditures and cost savings for children who can be expected to enter the state's child welfare system in the coming year. It does not attempt to project savings to the agency from reunifying children who are already in substitute care with their families. Because the number of children who will enter the foster care program in the coming year is unknown, estimates are based on the previous year's experience.

1. Client Data. Last year, 2145 children entered the state's foster care program. Sixty-seven percent (67%) went into foster family homes (1437 children in FFH). Twelve and a half percent (12.5%) went into institutions (268 children in institutions). The remaining 20.5% did not enter substitute care.* Based on current estimates, we conclude that 18% of the children entering foster family homes are from 0-4 years old; 29% are from 5-12 years old; and 53% are 13 or older. From this information, we can estimate that 1437 children will enter foster family homes in this fiscal year and that 268 children will enter institutions. The average length of time a child remains in substitute care in the sample state is 3 years.

2. Personnel Costs. The present cost of foster care for one child of any age includes, in addition to the monthly board rate, direct and indirect (administrative and overhead) costs for service.

The average worker salary is $13,500/annum plus 25% benefits or $16,875/annum. Supervisor estimated average salary is $17,500/annum plus 25% benefits of $21,875/annum. Indirect costs are estimated at 100% of annual salary plus benefits per staff person. Average and monthly salary costs are calculated in Table 2.

TABLE 2

COMPUTING MONTHLY SALARIES

Staff Salary	X 25% Benefits	X 2 (100% Indirect)	= Annual/12 Cost	= Monthly Cost
Worker				
$13,500	$3,375	$16,875	$33,750	$2,812.50
Supervisor				
$17,500	$4,375	$21,875	$43,750	$3,645.83

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* It must be assumed that these children were either returned home within a few days' time or were placed in "free-homes" of relatives or friends.

The mean foster care caseload ratio (median figures not available) in the state is 22.4:1. The caseload ratio for effective family-based service provision is estimated at 12:1. Therefore, estimated personnel costs per child per month are computed in Table 3.

TABLE 3

COMPUTING AVERAGE PER CASE COST

	Monthly Staff Cost	Average No. Cases per Worker	Average Cost per Child
FOSTER CARE			
Worker	$2,812.50	22.4	$125.56
Supervisor *	3,645.83	112	$ 32.55
FAMILY-BASED SERVICES			
Worker	2,812.50	12	$234.38
Supervisor *	3,645.83	60	60.76

* Supervising 5 workers each

3. Institutional Costs. The present average cost of institutional/residential care for one child is $1,217.83 per month, including the institution's direct and indirect costs. Direct and indirect costs to the Division of Social Services are assumed to be the same as family foster care services costs. Therefore, institutional care expenditures plus DSS expenditures per child average $1,375.94 per month. (Note: The costs of residential treatment-type placements are generally greater than the costs associated with custodial-type institutional placement and group home care. The placement expenditures for each would have greater value if analyzed separately. However, since these figures were not available, the average expenditure for all institutional placements is used.)

4. Present Value of Dollar Expended on Foster and Institutional Case. An important assumption is made in this analysis: if a dollar is committed today to out-of-home placement, and the average length of time that a child currently remains in out-of-

home placement is three years, then the money committed to today's placement is being committed, on average, for a period of three years.

Using a 10% discount factor for 3 years (the average length of time a child remains in out-of-home care), the total combined cost of foster and institutional care is $25,4000,000 as shown in Table 4.

TABLE 4

ANALYSIS OF FOSTER CARE AND INSTITUTIONAL CARE COST FOR 1705 CHILDREN

PV(FC) = Present Value of Foster Care (personnel) cost + Board cost X 12 months X number of children, discounted at .10 over 3 years.

PV(IC) = Present Value of Institutional Care, as above.

Discount factor for 3 years at 10% is 2.487*

Age	Number of Children	Cost per Child per Month	PV(FC)	PV(IC)
		Foster Care		
0-4	257	$ 286	$2,200,000**	
5-12	429	320	4,100,000	
13 & up	751	360	8,100,000	
		Total	14,400,000	
		Institutional Care		
All Ages	268	1,376		$11,000,000
	Total PV(FC) + PV(IC)		$25,400,000	

* Discount Factor is the present value of $1.00 received at a specified future date. Annuity tables are available to simplify determining the discount factor. Discount Rate (10% in this example) may differ from the rate used in your state.

** All figures rounded to nearest 1,000,000.

5. *Present Value of Dollars Expended on Family-Centered Prevention Services*. This analysis is based on the assumption that intensive family-centered services will prevent the placement of 60% of the children who, based on last year's data, can be expected to go into out-of-home care. Family-centered services is estimated to result in termination of services in less than one year. Therefore, present value estimates of expenditures can be discounted using a one year discount factor.

In family-centered services, the family, rather than the individual child, is the focus of service. Therefore, for the purpose of this analysis, the individual child unit of service has been converted to a family unit of service. Thus, 1023 child units (60% of 1705) have been reduced by an estimated 40% sibling groups to 614 family units as shown in Table 5.

TABLE 5

ANALYSIS OF FAMILY-BASED SERVICES COSTS
FOR 614 FAMILIES

Families	Worker & Supervisor Cost per Month	Present Value
614	$295	$2,000,000

Total PV(FBS) = $2,000,000

PV(FBS) = Present Value of Family Based Services
(worker cost + supervisory cost
X 12 months X number children,
discounted at .10 per 1 year.)

Discount factor for one year at 10% is .909.

For the 40 percent who are still expected to go into placement, the computation in Table 6 is made.

TABLE 6

ANALYSIS OF FOSTER CARE COST FOR 682 CHILDREN (40%) DISCOUNTED OVER 3 YEARS

Age	Number of Children	Cost/Child per month	PV(FC)/40%
0-4	103	$ 286	$ 900,000
5-12	172	320	1,600,000
13 & up	300	360	3,000,000
All ages Inst.	107	1,376	4,400,000
		Total PV(FC) =	$9,900,000

The present value to the state's division of social services of providing a level of family-based services that would prevent an estimated 60% children from substitute placements is as follows:

Total PV(FC) = PV(IC) + PV(FBS) = $11,900,000.

6. Savings in Foster Care Maintenance Expenditures. A percentage of substitute care maintenance expenditures (board and incidentals) is generally financed by the state with federal funds (Title IV-E). Since it may be possible to transfer a percentage of unused Title IV-E funds to Title IV-B for general child welfare services (including prevention services), an analysis of that portion of foster care expenditures most likely to be financed in this manner is relevant. The following are computations of the present value of maintenance costs presumed saved by preventing 60% children from entering substitute care.

TABLE 7

MAINTENANCE COSTS SAVED BY NOT PLACING 1023 CHILDREN IN FOSTER CARE

Age	Number of Children	Maintenance Cost per Month	Present Value
0-4	154	$ 128	$ 600,000
5-12	257	161	1,200,000
13 & up	451	203	2,700,000
All ages, Inst.	161	1,217	5,800,000
Total	1,023		$10,300,000

CONCLUSION

In this summary analysis, the assumption has been that by providing family-centered services at a level of effort determined by a given client family's needs, a significant number of children can be prevented from out-of-home placement. By subtracting the present value of the cost of family-centered services (determined solely on worker salary and caseload to worker ratios) from the benefits to the agency (the net present value of maintenance expenditures over the current average length of time a child remains in placement), it is possible to estimate the net benefits accruing to the agency as shown in Table 8.

TABLE 8

NET BENEFITS TO AGENCY

Benefits = Gains	Costs = Losses	Net Benefits
$10,300,000	$2,000,000	$8,324,000

Not taken into account are the training or retraining requirements for workers and supervisors to provide family-centered services and the potential costs of redesigning an existing service delivery system to incorporate a family-centered services model. However, the net benefits accruing to the agency because of a reduction in maintenance costs for substitute care appear to be sufficient to absorb these start up costs.

There is a point at which the population in substitute care and the average length of time a child remains in care both diminish so that prevention program experditures equal or exceed the costs of substitute placement. This has already occurred in several agencies.

Where family-centered services are implemented, placement is still a measure of family-centered services program efficiency. However, the benefits accruing to the agency in terms of savings in substitute care costs loses relevance except as an historical reminder. Under these circumstances, the agency may use cost-effectiveness analysis techniques to compare and contrast various other family-centered services program options to increase service efficiency.

GLOSSARY OF TERMS

ASSESSMENT:	An ongoing process of obtaining and evaluating information with and about a family, for purposes of service planning and delivery.
CASELOAD RATIO:	Refers to the number of client families per worker.
CASELOAD WEIGHTING:	The process of assigning measures to tasks and services as a means of allocating cases.
CATEGORICAL SERVICES:	Services provided by separate child welfare units organized according to the function provided (usually for the individual child), such as protective services, foster care and adoption.
CLIENT FAMILY:	The focus of service in the family-centered approach. The client family may consist of parents and children residing in the same household, as well as extended family or household members not related by marriage.
CLIENT OUTCOMES:	A measure used to refer to: client satisfaction with services received, client's situation at termination of services, or client's situation at a period of time after termination of services.
CLIENT PATHWAY:	Refers to the movement of clients in and out of the service delivery system. The client pathway in a social service agency can be diagrammed to examine problems in case movement, such as delays in service provision or discontinuity of services.
CORE SUPPORTS:	Services which may be part of the treatment plan and are supplemental to the efforts of the family-centered service worker (i.e., parent aide, homemaker, day care, respite care)

CRISIS:	An unanticipated, unusual event that requires immediate response and resolution.
DISCOUNTING:	Translating the value of money at one point in time to its value at another point in time.
DISCOUNT RATE:	A number relating value in one year to value in the next year or past year.
EMERGENCY NEEDS:	Pertains to families who are experiencing crises that require immediate and intense but short term intervention.
EXTRAORDINARY WORKWEEK:	A suggested re-organization of the working week to accommodate the flexible worker schedules. It redefines the traditional Monday-Friday to Monday-Sunday.
FAMILY-CENTERED SERVICES:	An approach to the delivery of social services which aims to maintain family unity through service systems which focus on whole families and the fit between service and need. Such services are usually delivered in the family's home and community.
FAMILY ECOLOGY:	Term used in family-centered social work to refer to a family's interactions with its total environment - neighborhood, community, work settings, etc.
FAMILY SYSTEMS THEORY:	A conceptual framework for analyzing family interaction based on the supposition that children and parents form complex systems which must be understood in order to assess individual behavior. (Refer to bibliography for more extensive reading.)
FAMILY TYPOLOGY:	Classification scheme for allocating cases to family service workers, based on the family's needs and worker time required to meet these needs.

FIXED TASKS:	Refers to work routinely performed by a class of workers and which may or may not relate to casework (i.e., forms completion, regularly scheduled staff management and training activities).
FOLLOW-THROUGH:	A function of the intake component, identifying appropriate referral resources and assisting a client in obtaining services.
FOLLOW-UP:	A function of the intake component, determining whether a client has been able to obtain and utilize services from an agency to which he/she was referred.
GENERALIST-SPECIALIST:	A proposed model of family-centered service delivery which eliminates categorical service units. Family service workers provide social services with the assistance of specialists in relevant program areas.
GOAL ATTAINMENT SCALING:	A method of assessing progress toward specified goals. Measurements are taken at various time intervals to monitor achievement of such goals.
INTENSIVE FAMILY SERVICE UNIT:	A model of family-centered service delivery in which a separate unit is established within the public agency.
LIMITED-SITUATIONAL NEEDS:	Pertains to families experiencing problems in one or two areas of functioning, and who, with time-limited efforts by the family-centered team, can function without the assistance of the agency.
MAINTENANCE NEEDS:	Pertains to families who have received family-centered services, but for whom such services have failed to remedy their problems. Service efforts beyond the point of providing intensive family services are limited to forestall out-of-home placement of children, with the possibility of renewed intensive services if changes in the family situation occur.

MULTIPLE-PROBLEM NEEDS:	Pertains to families which have many problems/needs (that may include child abuse or neglect), and which require intensive family-centered services in order to stabilize their situation.
PARENT AIDE:	A trained member of the family-centered service team who works one-on-one with a parent to provide nurturance and support, and to teach home management, parenting, and life skills. Parent aides may be employees or volunteers, and may be non-degreed, have associate degrees, or bachelor degrees. There are at least 20 terms used for these providers. Those with degrees may be called "parent trainers" or "teaching specialists".
PLACEMENT:	Relocation of a child from his or her family to a substitute living arrangement (foster care, group care, institutional care.) It is usually the result of a protective service investigation or parental request.
PRESENT VALUE:	Results from computing the value of money over time and comparing it to the equipment account of money we have now.
PREVENTION:	For purposes of this manual, prevention is defined as the deterrence of out-of-home placement of children.
PROJECT STATES:	Those states which are receiving technical assistance to implement family-centered services and training from the National Resource Center on Family-Based Services.
PURCHASE OF SERVICE MODEL:	A model of family-centered service delivery which relies on contracting with private social agencies for the provision of such services.
RESPITE CARE:	A brief out-of-home placement for a child, to provide temporary relief of family tension, and which may be part of a prevention or family unification plan.

REUNIFICATION:	The process of bringing parent(s) and children back together after a period of out-of-home placement, providing supportive services to ease the transition.
SERVICE DELIVERY SYSTEM:	Refers to the functions and tasks performed in relation to the direct provision of social services to clients.
SERVICE UNIT:	A measurable quantity of a resource, often specified by the increments of time.
SPECIAL NEEDS ADOPTION:	Services which are aimed at facilitating the adoption of children who may be handicapped, older, or members of a minority group.
SUBSTITUTE CARE:	Refers to any type of alternative living arrangement for children who have been (temporarily) removed from their parents' custody, including foster family care, group care, or residential treatment.
TASK FORCE:	A temporary group of representatives of family-serving organizations, who convene to review state policies and recommend strategies for designing and implementing Family-Based Services.
TRANSIENT NEEDS:	Pertains to families who require temporary assistance due to problems which may arise in their travel from one location to another.
VARIABLE TASKS:	Responsibilities performed on behalf of client families and which are determined by each family's needs.

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APPENDIX A

OREGON INTENSIVE FAMILY SERVICES CONTRACT REQUIREMENTS

OREGON CHILDREN'S SERVICES DIVISION

INTENSIVE FAMILY SERVICES CONTRACT REQUIREMENTS

I. General

In delivering services under the terms of the Intensive Family Services Program, the Provider will conduct systemic, time-limited, generic Family Therapy and will identify, coordinate and integrate appropriate Community Resources in order to assist the family in resolving relevant problems. The program will be organized to meet the following requirements:

A. Number of Staff:

1. family therapists.
2. clerical person.
3. supervisor.

B. Minimum Qualifications of Staff:

1. Supervisor: Shall have a Masters or Doctorate Degree in social work, psychology or counseling and five years of demonstrated professional experience providing family therapy and two years providing supervision.

2. Family Therapists: Must possess a Masters or Doctorate Degree in social work, psychology or counseling and a minimum of two years of continuous experience carrying a caseload of problem adolescents and their families during the past five years. A Baccalaureate Degree in social work, psychology, or counseling may be substituted for the above educational requirement with the agreement of Children's Services Division.

C. Number of Families:

Services will be provided to an average of families each month. Each family therapist will be responsible for a minimum of families per month.

D. Duration of Contract:

The Division anticipates that this contract will end on June 30, 1985. Services will begin on July 1, 1983, and shall be dependent upon an agreement being reached between the Division and the contractor regarding payment for services which will be consistent with legislative expectations.

E. Length of Time Families in Program:

Each family will receive up to 90 days of intensive family services. As a general rule, services should be directed toward enough problem resolution that the case will be closed after it has

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received up to a maximum of 35 hours of intervention and therapy. It is anticipated that 65% of the cases will be closed upon termination from Intensive Family Services treatment.

After the family has been terminated from IFS and the case gets referred back to the substitute care committee as the target child is again in danger of placement, the substitute care committee will refer the family back to IFS for review. If IFS makes a clinical judgement that they can prevent placement by providing additional services, they may do so. These additional services must be limited to a maximum of 18 hours of direct service provided over a period of 90 days.

This procedure will not reduce the monthly intake rate into the IFS project.

This requirement will not apply to cases where IFS recommended substitute care placement, as the treatment of choice, during the original 90 day treatment period.

F. Hours of Service:

A minimum of hours of direct service (therapist/client contact) to families will be provided each year under this contract.

G. Primary and Secondary Service Workers:

Each family will have an assigned primary worker and may have a secondary worker. The primary worker will ensure that the family problems are accurately assessed and that the family receives all required therapy and community resources services.

H. Location:

The family therapists and clerical staff will operate out of the Branch office in of the Children's Services Division. Furniture and normal supplies will be provided by CSD.

I. Success Level:

1. A minimum of 75% of the target children will remain at home during the 90 day treatment period.
2. A minimum of 75% of the possible days of care will be substitute care free during the ensuing 6 months from the point of IFS service entry or from the point the target child returns home in those cases in which the child is in care at the IFS entry point.

II. Clients to be Served:

A. Population of target children to be served is as follows:

1. Male and Female
2. Ages 0 to 18

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B. Children of families to be served have demonstrated some or all of the following characteristics:

1. Pushes or goes beyond parents' limits
2. Is assaultive or physically abusive
3. Has problems in school, including:
    a. Truancy
    b. Academic performance problems
    c. Disruptive behavior
4. Frequently runs away
5. Has been physically abused or neglected
6. Refuses help from his caseworker
7. Makes poor peer relationship choices
8. Has been or is engaged in criminal theft
9. Communicates poorly

C. The family profile reflects any of the following characteristics:

1. Experiencing poor communication
2. Parents are often abusing, rejecting, and/or neglecting
3. Single parent family, or the parents are in the process of divorcing, or are experiencing severe marital problems
4. One or both parents are experiencing physical or mental duress
5. Parents either cannot or will not set limits for child/children
6. Parents often dislike or blame the child
7. Parents have, in the past, refused help
8. Some evidence of alcohol or drug abuse on the part of the parent(s)

D. The family/clients will be divided into two general populations:

1. Primary Populations:
    a. Families with a child who has been approved by CSD Substitute Care Committee for placement in Family Foster Care.

    b. Families with a child who has been approved by CSD Substitute Care Committee for placement in group care (any substitute care funded through CSD other than Family Foster Care).

    c. Families with a child who has been committed to a state training school but has not yet been placed.

2. Secondary Populations:
    d. Families with a child returning home from placement in a State Training School. Such a child must be considered at risk of returning to substitute care.

e. Families with a child returning home from placement in a group care facility. Such a child must be considered at risk of returning to substitute care.

f. Families with a child returning home from placement in foster care who, without IFS, would remain in some form of substitute care.

g. Families with a child for whom the permanent plan is returning home from substitute care. Such a case must be designated as a permanent planning case.

3. Work to be Performed:

The services provided to each family must be systemic in approach, comprehensive, and directed toward rapid change. The services must include an assessment phase, a treatment phase (including planned follow-up), and a termination phase.

a. Assessment Phase

An assessment interview will be conducted by the IFS therapists. This interview may be completed as the initial phase of a multiple impact therapy session or as a time-limited initial session.

The outcome of the assessment interview will result in an accurate evaluation of the family and will account for the following:

1) Dysfunctional family system
2) Symptomatic behaviors of family members
3) Probable underlying causes
4) Community resources involved
5) Directions for interventions

b. Treatment Phase

An individual family treatment plan will be based on the outcome of the assessment interview. The treatment plan will emphasize ongoing family therapy while integrating the services of CSD workers and/or representatives of other community resources.

The ongoing treatment must include the following:

1) Regularly scheduled family therapy sessions which may or may not follow a multiple impact therapy session.

2) Linking the family to appropriate community resources who may provide services not included in the IFS programming. It is expected that some of these resources will be integrated into the treatment of the family while consultation or collaboration will occur with others.

3) Providing co-therapy as often as is possible.

4) Maintenance of telephone contacts as a means of insuring a high level of interaction with the family.

The treatment phase will result in a minimum of 75% diversion from substitute care as stated in I-I.

c. Termination Phase

It is expected that when the family will terminate with the IFS therapist(s) its' members will have increased their problem-solving capabilities to the degree that they will no longer have to rely on CSD to help them problem-solve as evidenced by sustained case closure following IFS.

4. Referral Process:

All of the children going into the IFS Program will be referred by a CSD caseworker who has taken the child's case before the CSD Substitute Care Committee and has received the committee's approval for an IFS referral.

Within 7 working days after the CSD Substitute Care Committee has agreed and decided that the child is a candidate for an IFS referral, the referring CSD worker and the primary IFS worker will jointly decide on an approach in contacting the family to report that they are being referred for Intensive Family Services.

5. Reporting and Documentation:

The IFS primary therapist will be responsible for completing an appropriate written treatment summary and a copy of the IFS Questionnaire and for submitting these documents to CSD within two weeks of a family's termination from the program. On the first working day of each month, the local IFS Director/Supervisor will complete and forward to CSD Central Office a copy of the IFS Monthly Report Form regarding the activities and services of the previous month. Copies of the IFS Questionnaire, the IFS Monthly Report, and the prescribed treatment summary outline are attached.